Supreme Court, U.S.
FILED
AUG 2 1986
JOSEPH F. SPANIOL, JR.
CLERK

(8)

No. 84-1601

IN THE

Supreme Court of the United States

OCTOBER TERM, 1985

AETNA LIFE INSURANCE CO.,
Appellant,

v.

MARGARET W. LAVOIE AND ROGER J. LAVOIE, SR.,
Appellees.

On Appeal From the Supreme Court of Alabama

JOINT APPENDIX

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Jurisdictional Statement Filed 4/9/85
Jurisdiction Postponed To Hearing On The Merits 6/3/85

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DOCKET ENTRIES IN SUPREME COURT OF ALABAMA*

AETNA LIFE & CASUALTY INSURANCE COMPANY, INC.
MARGARET W. LAVOIE AND ROGER J. LAVOIE, SR.
5cc 9-8-83 cm [app. brief filed]

10-6-83	cm Oral Argument Requested By Appellee Denied 11-17-83
11-17-83	Submitted ON BRIEFS (SET ASIDE 4-4-84) Division MADDOX DIVISION
4-4-84	CALLED ATTORNEYS RE: SETTING ASIDE SUBMISSION AND GRANTING OF ORAL ARGUMENT. (PER JTWA)
5-14-84	Submitted ARGUED & SUBMITTED Division TO,MA,FA,JO,AL,SH,EM,BE&AD
12-7-84	Judgment AFFIRMED
12-7-84	Opinion By PER CURIAM
12-7-84	Concurrences FAULKNER, JONES, ALMON, EMBRY & ADAMS, JJ., CONCUR; TORBERT, CJ., MADDOX, SHORES & BEATTY, JJ., DISSENT.
12-21-84	Application for Rehearing Filed brief due 12-28-84 Alg BRIEFS FILED: 12-28-84 (9 copies)
1-4-85	Called J. Brown re: filing reply to rehearing by filed by Sintz and Cunningham by 1-18-85. Brown may respond to amicus briefs at own discretion. NTWA/TB/sjm
1-7-85	1cc John Crowder's Motion for Extension of Time for 14 additional days to File Brief in Response to Application for Rehearing—granted to 2-1-85
1-9-85	Letter from Joseph Brown confirming the filing date of January 18, 1985 for filing brief in response to appellant's brief in support of its motion for rehearing/awk-JTWA
	Response to Rehearing Briefs filed 1-17-85 (9 copies) [appellees brief]

*The relevant docket entries are printed in chronological order, thereby not necessarily reflecting the order in which they appear on the three-page docket sheet which was lodged by appellant with the Clerk of this Court on April 9, 1985 and which has also been forwarded to the clerk of this Court by the clerk of the Supreme Court of Alabama in connection with transmittal of the record by the latter to this Court.

2-22-85	9 cc Appellant's Motion for Disqualification and Motion for Withdrawal of Opinion of December 7, 1984 and for Hearing De Novo/awk-JTWA
3-1-85	9cc Appellees', Margaret and Roger Lavoie, Objection to Motion for Disqualification and Motion for Withdrawal of Opinion and for Hearing De Novo/ awk-JTWA
3-1-85	10cc Application and Brief of Amicus Curiae filed by the Alabama Trial Lawyers Association/awk-JTWA
3-7-85	10cc Amendment to motion for disqualification and motion for withdrawal of opinion of 12-7-84 and for hearing de novo (filed by Sintz and Cunningham)
3-8-85	Action on Rehearing OVERRULED—(ALL JJ STAY AS WERE ON ORIGINAL OPINION) MOTION FOR DISQUALIFICATION AND WITHDRAWAL OF OPINION OF 12-7-84 AND FOR HEARING DE NOVO DENIED. (Fau, Jo, Al, Bea & Ad, conour; Tor, Ma & Sh, JJ, concurring specially to deny)
3-22-85	10cc—Appellant's Motion to Suspend the Rules and Motion for Stay bof Execution of Judgment/awk-bjmc-Court
3-22-85	10cc—Amendment to Appellant's Motion to Suspend Rules and Motion for Stay of Execution of Judgment/ awk-bjmc-Court
3-25-85	ORDERED that the motion to suspend rules and motion for stay of execution of judgment and the amendment to motion to suspend rules and motion for stay of execution of judgment be, and the same are hereby, denied. Torbert, C. J., and Maddox, Faulkner, Almon, Shores, Embry, Beatty, and Adams, JJ., concur; Jones, J., not sitting. lbl
3-25-85	2cc Appellant's Notice of Appeal to Supreme Court of the United States/awk-dn

CIVIL CASE ACTION SUMMARY*

Case Number CV-78-001614

In the Circuit Court of Mobile County *Margaret W. Lavoie and Roger J. Lavoie, Sr. v. Aetna Life and Casualty Co., Inc.*, a corporation.

9-29-78	Complaint & Summons
10-17-78	Defendant's motion for court to dismiss the complaint.
11-17-78	Motion to dismiss the complaint under Count 1, denied; Count 2, 3, 4 and 5, dismissed with prejudice.
12-15-78	Amended Complaint
12-15-78	Notice of Appeal to the Supreme Court filed this date by the Plaintiffs from the order of November 17, 1978 dismissing counts 2, 3, 4 and 5.
9-4-79	Opinion received this date from the Supreme Court reversing and remanding.
9-20-79	Certificate of reversal received this date from the Supreme Court. ORDERED that the judgment of the circuit court be reversed and annulled and that this cause be remanded to the court below for further proceedings therein. FURTHER ORDERED that the appellee, Aetna Life and Casualty Company, Inc., a corporation, pay the costs of appeal as provided by the ARAP, for which costs let execution issue.
2-29-80	Plaintiffs' second amended complaint (NO SUMMONS)
8-21-80	Third Amended Complaint.
9-22-80	Defendant's motion for court to enter a summary judgment in its favor dismissing the complaint.
10-10-80	Motion granted as to Counts 2, 3, 5 & 6; Denied as to others.
12-12-80	Appeal docketed. No. 80-149.

*These pertinent Docket entries are found in the record at pp. 65-71.

10-5-81	Opinion from Supreme Court: The judgment of the Circuit Court of Mobile County, Alabama is reversed and remanded with directions to that court to reconsider the insurer's motion for summary judgment in the light of the teachings of *Chavers*.
10-26-81	Certificate of judgment dated October 2, 1981 received this date from the Supreme Court. ORDERED AND ADJUDGED that the judgment of the Circuit Court be reversed and annulled and that this cause be remanded to the Circuit Court with directions to reconsider the insurer's motion for summary judgment, in the light of the decision in Chavers v. National Security Fire and Casualty Company. FURTHER ORDERED that the appellee, Aetna Life and Casualty Company, Inc., a corporation, pay the costs of appeal as provided by the RAP, for which costs let execution issue.
11-16-81	Fourth Amended Complaint—Adding Counts 7 and 8 (No summons issued.)
11-3-82	Defendant, Aetna Life and Casualty Company, Inc's motion for directed verdict filed at close of plaintiff's case. November 4, 1982—Jury and Verdict for the plaintiffs and against the defendant for the sum of $3,501,650.22.
12-20-82	Defendant's brief in support of motion for new trial, judgment notwithstanding the verdict, and remittitur.
12-29-82	Plaintiffs' reply brief on motion for new trial, judgment notwithstanding the verdict, and remittitur.
2-10-83	Notice of Appeal to the Supreme Court filed this date by the Defendant from the jury and verdict of November 4, 1982 in favor of Plaintiffs and against defendant for $3,501.650.22 and from the order of January 28, 1983 denying defendant's motion for Court to enter a verdict in favor of the defendant or in the alternative for a remittitur, or in the alternative a new trial.

2-10-83	Supersedes Bond in the amount of $4,377,062.78 filed with The Aetna Casualty and Surety Co., surety.
2-10-83	$50.00 docket fee.
2-10-83	Designation of Record on Appeal.
2-10-83	Letter of transmittal.
2-24-83	Appeal docketed. No. 82-426.

IN THE CIRCUIT COURT OF MOBILE COUNTY, ALABAMA

Civil Action No. CV-78-001614

MARGARET W. LAVOIE and ROGER J. LAVOIE, SR.,

Plaintiffs.

-VS-

AETNA LIFE AND CASUALTY COMPANY, INC., a corporation; A, B, and C, the person, firm, or corporation which issued the policy made the subject and basis of this suit; D, E, and F, the person, firm or corporation charged with the responsibility of exercising good faith and due care in the payment of benefits under the policy made the basis of this suit; whose names and legal identities are unknown to the Plaintiff at this time, but which will be substituted by amendment when ascertained,

Defendants.

FIRST CAUSE OF ACTION

1. The Plaintiff, Margaret W. Lavoie, alleges that heretofore and on, to-wit, February 3, 1977, the Plaintiff entered the Mobile Infirmary, Mobile, Alabama, to undergo a series of tests which had been prescribed by her physician.

2. As a result of the above described hospital confinement between February 3 and February 26, 1977, the Plaintiff incurred a total charge from the Mobile Infirmary of Three Thousand Twenty-eight and 25/100 ($3,028.25) Dollars.

3. The Plaintiff further alleges that at the time the said hospital expenses were incurred and for some period of time previous thereto, she was an insured beneficiary within the terms of a Group Policy of Health and Medical Insurance issued by the Defendant, Aetna Life and Casualty Company,

[1]*

Inc. (Hereinafter referred to as Aetna), and issued to the City of Mobile as policyholder and which was in full force and effect at the time the said expenses were incurred, the said City of Mobile having paid premiums to the Defendant, Aetna, for the Plaintiff's benefit.

4. The Plaintiff further alleges that the expenses incurred by her while confined to the Mobile Infirmary during the above described period were expenses which the Defendant, Aetna, had contracted to pay and were under a duty to pay under the terms and conditions of the policy of insurance issued by the Defendant, Aetna, to the City of Mobile as policyholder.

5. The Plaintiff further alleges that the Defendant, Aetna, is a foreign corporation doing business in Mobile County, Alabama.

6. The Plaintiff further alleges that the Defendant, Aetna, did pay a portion of the total charge incurred by the Plaintiff as a result of her above described confinement, but that the Defendant, Aetna, has steadfastly refused the demands of the Plaintiff to pay the balance due on her account of One Thousand Six Hundred Fifty and 22/100 ($1,650.22) Dollars.

7. The Plaintiff further alleges that the refusal of the Defendant, Aetna, to pay the said benefits due under the contract of insurance constitutes a breach of the contract of insurance under which the Plaintiff is a beneficiary.

WHEREFORE, the Plaintiff, MARGARET W. LAVOIE, demands judgment of the Defendant in the amount of ONE THOUSAND SIX HUNDRED FIFTY and 22/100 ($1,650.22) DOLLARS, plus costs and interest.

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*Page no. of record on initial appeal of case to Supreme Court of Alabama.

SECOND CAUSE OF ACTION

1. The Plaintiff, MARGARET W. LAVOIE, realleges all of the allegations contained in Paragraphs 1, 2, 3, 4, 5, and 6 of the First Cause of Action.

7. The Plaintiff further alleges against the Defendant, Aetna, that subsequent to the initial denial of benefits by the Defendant on the grounds that the tests performed on the Plaintiff should have been incurred in an outpatient rather than an inpatient basis, the Plaintiff supplied the Defendant with medical reports from her admitting physician which recited the fact that at the time of her admission into the hospital, the controller atmosphere of the hospital was necessary to carry out the required testing and observation of the Plaintiff.

8. The Plaintiff further alleges that the steadfast refusal of the Defendant to pay the claimed benefits in light of the evidence available to the Defendant in the form of the admitting physician's reports regarding the necessity of her treatment as an inpatient, constituted outrageous, malicious and oppressive conduct on the part of the Defendant and exhibited wanton and reckless disregard of the probability of causing severe emotional distress to the Plaintiff.

9. The Plaintiff further alleges that as a proximate result of the Defendant's reckless, wanton, malicious, oppressive and outrageous conduct in the denial of the said claim, she has been caused to suffer the following injuries: she has suffered severe emotional distress; she has been caused to see numerous physicians, psychologists and psychiatrists for treatment of her emotional distress; she has suffered a complete

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and total nervous breakdown; she has been permanently injured; she has, as a result of her severe emotional distress, suffered severe bodily dysfunction proximately resulting from her emotional distress; she was caused to be voluntarily committed to the Searcy Mental Hospital; she has suffered much

embarrassment, humiliation, and sleeplessness; she has suffered much pain and suffering, both physical and mental, still so suffers, and will so suffer in the future; and her credit and reputation have been damaged.

WHEREFORE, the Plaintiff, MARGARET W. LAVOIE, demands judgment of the Defendant in the amount of ONE MILLION ($1,000,000.00) DOLLARS as compensatory and punitive damages.

THIRD CAUSE OF ACTION

1. The Plaintiff, MARGARET W. LAVOIE, realleges the allegations contained in Paragraphs 1, 2, 3, 4, 5, 6, and 7 of the Second Cause of Action.

8. The Plaintiff further alleges that the refusal of the Defendant to pay the claimed benefits in light of the evidence available to the Defendant in the form of the admitting physician's reports regarding the necessity of her treatment as an inpatient constituted a negligent and/or wanton breach of the implied duty to deal in good faith in its contractual relationships, and of the implied duty to exercise due care in the performance of its contractual obligations.

9. The Plaintiff further alleges that as a proximate result of the negligence and/or wantonness of the Defendant in tortiously breaching the implied duties of good faith in

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its dealings and of due care in the performance of its obligations under the contract, the Plaintiff sustained the injuries as set forth in Paragraph 8 of the Second Cause of Action and incorporates the same by reference herein.

WHEREFORE, the Plaintiff, MARGARET W. LAVOIE, demands judgment of the Defendant in the amount of ONE MILLION ($1,000,000.00) DOLLARS as compensatory and punitive damages.

FOURTH CAUSE OF ACTION

1. Plaintiff, ROGER J. LAVOIE, SR., who is the husband of the Plaintiff, Margaret W. Lavoie, realleges all of the allegations contained in Paragraphs 1, 7, 8, and 9 of the Second Cause of Actiion.

10. The Plaintiff alleges that as a further proximate result of the Defendant's reckless, wanton, malicious, oppressive and outrageous conduct in the denial of the said claim and the injuries to his said wife, he was caused to lose the services and consortium of his said wife over a long period of time and will lose her services and consortium in the future.

WHEREFORE, Plaintiff, ROGER J. LAVOIE, SR., demands judgment of the Defendant in the amount of ONE HUNDRED THOUSAND ($100,000.00) DOLLARS as compensatory and punitive damages.

FIFTH CAUSE OF ACTION

1. Plaintiff, ROGER J. LAVOIE, SR., who is the husband of the Plaintiff, Margaret W. Lavoie, realleges the allegations of Paragraphs 1, 8, and 9 of the Third Cause of Action.

10. The Plaintiff further alleges that as a proximate result of the negligence and/or wantonness of the Defendant in tortiously breaching the implied duties of good faith in its dealings and of due care in the performance of its obligations under the contract and the injuries to his said wife,

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he was caused to lose the services and consortium of his said wife over a long period of time and will lose her services and consortium in the future.

WHEREFORE, Plaintiff, ROGER J. LAVOIE, SR., demands judgment of the Defendant in the amount of ONE THOUSAND ($100,000.00) DOLLARS as compensatory and punitive damages.

CUNNINGHAM, BOUNDS, BYRD, YANCE
AND CROWDER
Attorneys for Plaintiffs

BY: _____
JOSEPH M. BROWN, JR.
P.O. Box 66705
Mobile, Alabama 36606

_____
THOMAS E. HARRISON
Attorney for Plaintiffs
P.O. Box 433
Mobile, Alabama 36601

Plaintiffs respectfully demand a trial by jury of this cause.

_____
JOSEPH M. BROWN, JR.

Defendant may be served at:

Aetna Life and Casualty Company, Inc.
951 Government Street—Suite 500
Mobile, Alabama

IN THE CIRCUIT COURT OF MOBILE COUNTY, ALABAMA

Civil Action No. CV 78-001614

MARGARET W. LAVOIE and ROBERT J. LAVOIE, SR.,
Plaintiffs

VS.

AETNA LIFE AND CASUALTY COMPANY, INC., a corporation; A, B and C, the person, firm, or corporation which issued the policy made the subject and basis of this suit, D, E and F, the person, firm, or corporation charged with the responsibility of exercising good faith and due care in the payment of benefits under the policy made the basis of this suit; whose names and legal identities are unknown to the Plaintiff at this time, but which will be substituted by amendment when ascertained,
Defendants

AMENDED COMPLAINT

Come the Plaintiffs in the above styled cause, the Second, Third, Fourth and Fifth Causes of Action having been dismissed and Final Judgment thereon having been entered by Order of the Court dated November 17, 1978, and amend the complaint filed heretofore in said action so that body of the complaint shall read as follows:

FIRST CAUSE OF ACTION

1. The Plaintiff, MARGARET W. LAVOIE, alleges that heretofore and on, to-wit, February 3, 1977, the Plaintiff entered the Mobile Infirmary, Mobile, Alabama, to undergo a series of tests which had been prescribed by her physician.

2. As a result of the above described hospital confinement between February 3 and February 26, 1977, the Plaintiff in-

curred a total charge from the Mobile Infirmary of Three Thousand Twenty-eight and 25/100 ($3,028.25) Dollars.

3. The Plaintiff further alleges that at the time the said hospital expenses were incurred and for some period of time

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previous thereto, she was insured beneficiary within the terms of a Group Policy of Health and Medical Insurance issued by the Defendant, Aetna Life and Casualty Company, Inc. (hereinafter referred to as Aetna), and issued to the City of Mobile as policyholder and which was in full force and effect at the time the said expenses were incurred, the said City of Mobile having paid premiums to the Defendant, Aetna, for the Plaintiff's benefit.

4. The Plaintiff further alleges that the expenses incurred by her while confined to the Mobile Infirmary during the above described period were expenses which the Defendant, Aetna, had contracted to pay and were under a duty to pay under the terms and conditions of the policy of insurance issued by the Defendant, Aetna, to the City of Mobile as policyholder.

5. The Plaintiff further alleges that the Defendant, Aetna, as a foreign corporation doing business in Mobile County, Alabama.

6. The Plaintiff further alleges that the Defendant, Aetna, did pay a portion of the total charge incurred by the Plaintiff as a result of her above described confinement, but that the Defendant, Aetna, has steadfastly refused the demands of the Plaintiff to pay the balance due on her account of One Thousand Six Hundred Fifty and 22/100 ($1,650.22) Dollars.

7. The Plaintiff further alleges that the refusal of the Defendant, Aetna, to pay the said benefits due under the contract of insurance constitutes a breach of the contract of insurance under which the Plaintiff is a beneficiary.

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*Page no. of record on initial appeal of case to Supreme Court of Alabama.

WHEREFORE, The Plaintiff, MARGARET W. LAVOIE, demands judgment of the Defendant in the amount of ONE THOUSAND SIX HUNDRED FIFTY and 22/100 ($1,650.22) DOLLARS, plus costs and interests.

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SIXTH CAUSE OF ACTION

1. The Plaintiff, MARGARET W. LAVOIE, realleges and incorporates by reference all of the allegations contained in paragraphs 1, 2 and 3 of the First Cause of Action.

4. The Plaintiff further alleges that the expenses incurred by her while confined to the Mobile Infirmary during the above described period were expenses which the Defendant, Aetna, had fraudulently represented to the Plaintiff that the Defendant would pay under the terms and conditions of the policy of insurance issued by the Defendant, Aetna.

5. The Plaintiff further alleges that the expenses incurred by her while confined to the Mobile Infirmary during the above described period were incurred in justifiable reliance upon the representation by the Defendant, Aetna, that such expenses would be paid under the provisions of the policy of insurance issued by the Defendant, Aetna, for the Plaintiff's benefit.

6. The Plaintiff further alleges that the Defendant, Aetna, is a foreign corporation doing business in Mobile County, Alabama.

7. The Plaintiff further alleges that as a proximate consequence of the fraudulent representations by the Defendant, Aetna, that the charges incurred by the Plaintiff as a result of the above described period of hospital confinement would be paid under the provisions of the above described policy of insurance, the Plaintiff has sustained a loss of ONE THOUSAND SIX HUNDRED FIFTY and 22/100 ($1,650.22) DOLLARS which represents that portion of the hospital expenses incurred by the Plaintiff which the Defendant has refused to pay.

WHEREFORE, the Plaintiff, MARGARET W. LAVOIE, demands judgment against the Defendant in the amount of ONE THOUSAND SIX HUNDRED FIFTY AND 22/100 ($1,650.22) DOLLARS as compensatory damages and FIFTY THOUSAND ($50,000.00) DOLLARS as punitive damages plus costs.

CUNNINGHAM, BOUNDS, BYRD
YANCE & CROWDER

BY:_____
JOSEPH M. BROWN, JR.

I do hereby certify that I on this 22 day of November 1978, served a copy of the foregoing Amended Complaint on Pete Sintz, Esquire, 3100 Cottage Hill Road, Mobile, Alabama by mailing same postage prepaid.

_____
JOSEPH M. BROWN, JR.

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IN THE CIRCUIT COURT OF MOBILE COUNTY, ALABAMA

Civil Action No. CV-78-001614

MARGARET W. LAVOIE and ROGER J. LAVOIE, SR.,
Plaintiffs

-VS-

AETNA LIFE AND CASUALTY COMPANY, INC., A CORPORATION, *et al.*,
Defendants.

SECOND AMENDED COMPLAINT

Come the Plaintiffs in the above styled cause and amend the body of the complaint filed heretofore in this cause to read as follows:

FIRST CAUSE OF ACTION

1. The Plaintiff, Margaret W. Lavoie, alleges that heretofore and on, to-wit, February 3, 1977, the Plaintiff entered the Mobile Infirmary, Mobile, Alabama, to undergo a series of tests which had been prescribed by her physician.

2. As a result of the above described hospital confinement between February 3 and February 26, 1977, the Plaintiff incurred a total charge from the Mobile Infirmary of Three Thousand Twenty-eight and 25/100 ($3,028.25) Dollars.

3. The Plaintiff further alleges that at the time the said hospital expenses were incurred and for some period of time previous thereto, she was an insured beneficiary within the terms of a Group Policy of Health and Medical Insurance issued by the Defendant, Aetna Life and Casualty Company, Inc. (hereinafter referred to as Aetna), and issued to the City of

Mobile as policyholder and which was in full force and effect at the time the said expenses were incurred, the said City of Mobile having paid premiums to the Defendant, Aetna, for the Plaintiff's benefit.

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4. The Plaintiff further alleges that the expenses incurred by her while confined to the Mobile Infirmary during the above described period were expenses which the Defendant, Aetna, had contracted to pay and were under a duty to pay under the terms and conditions of the policy of insurance issued by the Defendant, Aetna, to the City of Mobile as policyholder.

5. The Plaintiff further alleges that the Defendant, Aetna, is a foreign corporation doing business in Mobile County, Alabama.

6. The Plaintiff further alleges that the Defendant, Aetna, did pay a portion of the total charge incurred by the Plaintiff as a result of her above described confinement, but that the Defendant, Aetna, has steadfastly refused the demands of the Plaintiff to pay the balance due on her account of One Thousand Six Hundred Fifty and 22/100 ($1,650.22) Dollars.

7. The Plaintiff further alleges that the refusal of the Defendant, Aetna, to pay the said benefits due under the contract of insurance constitutes a breach of the contract of insurance under which the Plaintiff is a beneficiary.

WHEREFORE, the Plaintiff, Margaret W. Lavoie, demands judgment of the Defendant in the amount of ONE THOUSAND SIX HUNDRED FIFTY and 22/100 ($1,650.22) DOLLARS, plus costs and interest.

SECOND CAUSE OF ACTION

1. The Plaintiff, Margaret W. Lavoie, realleges all of the allegations contained in Paragraphs 1, 2, 3, 4, 5 and 6 of the First Cause of Action.

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*Page no. of record on second appeal of case to Supreme Court of Alabama.

7. The Plaintiff further alleges against the Defendant, Aetna, that subsequent to the initial denial of benefits by

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the Defendant on the grounds that the tests performed on the Plaintiff should have been incurred in an outpatient rather than an inpatient basis, and at the Defendant's request that a medical report from the admitting physician be supplied to the Defendant, the Plaintiff supplied the Defendant with medical reports from her admitting physician which recited the fact that at the time of her admission into the hospital, the controlled atmosphere of the hospital was necessary to carry out the required testing and observation of the Plaintiff.

8. The Plaintiff further alleges that the steadfast refusal of the Defendant to pay the claimed benefits in light of all of the evidence available to the Defendant, particularly in the form of the hospital records, nursing notes and admitting physician's reports regarding the necessity of her treatment as an inpatient, constituted outrageous, malicious and oppressive conduct on the part of the Defendant and exhibited wanton and reckless disregard of the probability of causing severe emotional distress to the Plaintiff.

9. The Plaintiff further alleges that as a proximate result of the Defendant's reckless, wanton, malicious, oppressive and outrageous conduct in the denial of the said claim, she has been caused to suffer the following injuries: she has suffered severe emotional distress; she has suffered much embarrassment, humiliation, and sleeplessness; she has suffered emotionally, still so suffers, and will so suffer in the future; and her credit and reputation have been damaged.

WHEREFORE, the Plaintiff, Margaret W. Lavoie, demands judgment of the Defendant in the amount of ONE MILLION ($1,000,000.00) DOLLARS as compensatory and punitive damages.

THIRD CAUSE OF ACTION

1. The Plaintiff, Margaret W. Lavoie, realleges the allegations contained in Paragraphs 1, 2, 3, 4, 5, 6, and

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7 of the Second Cause of Action.

8. The Plaintiff further alleges that the refusal of the Defendant to pay the claimed benefits in light of all of the evidence available to the Defendant, particularly in the form of the hospital records, nurse's notes and admitting physician's reports regarding the necessity of her treatment as an inpatient constituted a reckless and/or wilful and/or wanton breach of the implied duty to deal in good faith in its contractual relationships, and of the implied duty to exercise due care in the performance of its contractual obligations.

9. The Plaintiff further alleges that as a proximate result of the above described reckless, wilful and/or wanton conduct of the Defendant in tortiously breaching the implied duties of good faith in its dealings and of due care in the performance of its obligations under the contract, the Plaintiff sustained the injuries as set forth in Paragraph 9 of the Second Cause of Action and incorporates the same by reference herein.

WHEREFORE, the Plaintiff, Margaret W. Lavoie, demands judgment of the Defendant in the amount of ONE MILLION ($1,000,000.00) DOLLARS as compensatory and punitive damages.

FOURTH CAUSE OF ACTION

1. The Plaintiff, Roger J. Lavoie, Sr., who is the husband of the Plaintiff, Margaret W. Lavoie, alleges that on, to-wit, February 3, 1977, the said Margaret W. Lavoie entered the Mobile Infirmary, Mobile, Alabama, to undergo a series of tests which had been prescribed by her physician, for which the Plaintiff Roger J. Lavoie, Sr., incurred a total charge from the Mobile Infirmary of Three Thousand Twenty-eight and

25/100 ($3,028.25) Dollars for treatment of his said wife between February 3 and February 26, 1977.

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2. The Plaintiff further alleges that at the time the said hospital expenses were incurred and for some period of time previous thereto, he was an insured beneficiary within the terms of a Group Policy of Health and Medical Insurance issued by the Defendant, Aetna Life and Casualty Company, Inc., and issued to the City of Mobile as policyholder and which was in full force and effect at the time the said expenses were incurred, the said City of Mobile having paid premiums to the Defendant, Aetna, for the Plaintiff's benefit.

3. The Plaintiff further alleges that the expenses incurred by him due to his said wife's hospitalization in the Mobile Infirmary during the the above described period were expenses which the Defendant, Aetna, had conracted to pay and were under a duty to pay under the terms and conditions of the policy of insurance issued by the Defendant, Aetna, to the City of Mobile as policyholder.

4. The Plaintiff further alleges that the Defendant, Aetna, is a foreign corporation doing business in Mobile County, Alabama.

5. The Plaintiff further alleges that the Defendant, Aetna, did pay a portion of the total charge incurred by the Plaintiff as a result of his said wife's above described confinement, but that the Defendant, Aetna, has steadfastly refused the demands of the Plaintiff to pay the balance due on his account of One Thousand Six Hundred Fifty and 22/100 ($1,650.22) Dollars.

6. The Plaintiff further alleges that the refusal of the Defendant, Aetna, to pay the said benefits due under the contract of insurance constitutes a breach of the cont. act of insurance under which the Plaintiff is a beneficiary.

WHEREFORE, the Plaintiff, Roger J. Lavoie, Sr., demands judgment of the Defendant in the amount of ONE THOUSAND SIX

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HUNDRED FIFTY and 22/100 ($1,650.22) DOLLARS, plus costs and interest.

FIFTH CAUSE OF ACTION

1. The Plaintiff, Roger J. Lavoie, Sr., realleges all of the allegations contained in Paragraphs 1, 2, 3, 4 and 5 of the Fourth Cause of Action and incorporates the same by reference herein.

6. The Plaintiff further alleges against the Defendant, Aetna, that subsequent to the initial denial of benefits by the Defendant on the grounds that the tests performed on the Plaintiff's wife, Margaret W. Lavoie, should have been incurred in an outpatient rather than an inpatient basis, and at the Defendant's request that a medical report from the admitting physician be supplied to the Defendant, the Plaintiff supplied the Defendant with medical reports from his said wife's admitting physician which recited the fact that at the time of the Plaintiff's wife's admission into the hospital, the controlled atmosphere of the hospital was necessary to carry out the required testing and observation of the Plaintiff's wife.

7. The Plaintiff further alleges that the steadfast refusal of the Defendant to pay the claimed benefits in light of all of the evidence available to the Defendant, particularly in the form of the hospital records, nursing notes and admitting physician's reports regarding the necessity of his wife's treatment as an inpatient, constituted outrageous, malicious and oppressive conduct on the part of the Defendant and exhibited wanton and reckless disregard of the probability of causing severe emotional distress to the Plaintiff.

8. The Plaintiff further alleges that as a proximate result of the Defendant's reckless, wanton, malicious, oppressive and

outrageous conduct in the denial of the said claim, he has been caused to suffer the following injuries: he has suffered severe emotional distress; he has suffered much embarrassment, humiliation, and sleeplessness; he

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has suffered emotionally, still so suffers, and will so suffer in the future; and his credit and reputation have been damaged.

WHEREFORE, the Plaintiff, Roger J. Lavoie, Sr., demands judgment of the Defendant in the amount of ONE MILLION ($1,000,000.00) DOLLARS as compensatory and punitive damages.

SIXTH CAUSE OF ACTION

1. The Plaintiff, Roger J. Lavoie, Sr., realleges all of the allegations contained in Paragraphs 1, 2, 3, 4, 5 and 6 of the Fifth Cause of Action and incorporates the same by reference herein.

7. The Plaintiff further alleges that the refusal of the Defendant to pay the claimed benefits in light of all of the evidence available to the Defendant, particularly in the form of the hospital records, nurse's notes and admitting physician's reports regarding the necessity of his wife's treatment as an inpatient constituted a reckless and/or wilful and/or wanton breach of the implied duty to deal in good faith in its contractual relationships, and of the implied duty to exercise due care in the performance of its contractual obligations.

8. The Plaintiff further alleges that as a proximate result of the above described reckless, wilful and/or wanton conduct of the Defendant in tortiously breaching the implied duties of good faith in its dealings and of due care in the performance of its obligations under the contract, the Plaintiff sustained the injuries as set forth in Paragraph 8 of the Fifth Cause of Action.

WHEREFORE, the Plaintiff, Roger J. Lavoie, Sr., demands judgment of the Defendant in the amount of ONE MILLION ($1,000,000.00) DOLLARS as compensatory and punitive damages.

[360]

CUNNINGHAM, BOUNDS, BYRD,
YANCE & CROWDER
Attorneys for Plaintiffs

BY:_____
JOSEPH M. BROWN, JR.

Plaintiffs respectfully demand a trial by jury.

BY:_____
JOSEPH M. BROWN, JR.

IN THE CIRCUIT COURT OF MOBILE COUNTY, ALABAMA

Civil Action No. CV-78-001614

MARGARET W. LAVOIE and ROGER J. LAVOIE, SR.,
Plaintiffs,

-VS-

AETNA LIFE & CASUALTY CO., INC., a corporation, *et al.*,
Defendants.

THIRD AMENDED COMPLAINT

Come the Plaintiffs in the above styled cause and amend the body of the complaint filed heretofore in this cause to read as follows:

FIRST CAUSE OF ACTION

1. The Plaintiff, Margaret W. Lavoie, alleges that heretofore and on, to-wit, February 3, 1977, the Plaintiff entered the Mobile Infirmary, Mobile, Alabama, to undergo a series of tests which had been prescribed by her physician.

2. As a result of the above described hospital confinement between February 3 and February 26, 1977, the Plaintiff incurred a total charge from the Mobile Infirmary of Three Thousand Twenty-eight and 25/100 ($3,028.25) Dollars.

3. The Plaintiff further alleges that at the time the said hospital expenses were incurred and for some period of time previous thereto, she was an insured beneficiary within the terms of a Group Policy of Health and Medical Insurance issued by the Defendant, Aetna Life and Casualty Company, Inc. (hereinafter referred to as Aetna), and issued to the City of Mobile as policyholder and which was in full force and effect at

the time the said expenses were incurred, the said City of Mobile having paid premiums to the Defendant, Aetna, for the Plaintiff's benefit.

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4. The Plaintiff further alleges that the expenses incurred by her while confined to the Mobile Infirmary during the above described period were expenses which the Defendant, Aetna, had contracted to pay and were under a duty to pay under the terms and conditions of the policy of insurance issued by the Defendant, Aetna, to the City of Mobile and policyholder.

5. The Plaintiff further alleges that the Defendant, Aetna, is a foreign corporation doing business in Mobile County, Alabama.

6. The Plaintiff further alleges that the Defendant, Aetna, did pay a portion of the total charge incurred by the Plaintiff as a result of her above described confinement, but that the Defendant, Aetna, has steadfastly refused the demands of the Plaintiff to pay the balance due on her account of One Thousand Six Hundred Fifty and 22/100 ($1,650.22) Dollars.

7. The Plaintiff further alleges that the refusal of the Defendant, Aetna, to pay the said benefits due under the contract of insurance constitutes a breach of the contract of insurance under which the Plaintiff is a beneficiary.

WHEREFORE, the Plaintiff demands judgment against the Defendants in the sum of ONE THOUSAND SIX HUNDRED FIFTY AND 22/100 DOLLARS plus costs and interest.

SECOND CAUSE OF ACTION

1. The Plaintiff, Margaret W. Lavoie, realleges all of the allegations contained in Paragraphs 1, 2, 3, 4, 5 and 6 of the First Cause of Action and incorporates the same by reference herein.

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*Page no. of record on second appeal to Supreme Court of Alabama.

7. The Plaintiff further alleges against the Defendant, Aetna, that subsequent to the initial denial of benefits by the Defendant on the grounds that the tests performed on the Plaintiff should have been incurred in an outpatient rather than an inpatient basis, and at the Defendant's request that

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a medical report from the admitting physician be supplied to the Defendant, the Plaintiff supplied the Defendant with medical reports from her admitting physician which recited the fact that at the time of her admission into the hospital the controlled atmosphere of the hospital was necessary to carry out the required testing and observation of the Plaintiff.

8. The Plaintiff further alleges that the steadfast refusal of the Defendant to pay the claimed benefits in light of all of the evidence available to the Defendant, particularly in the form of the hospital records, nursing notes and admitting physician's reports regarding the necessity of her treatment as an inpatient, constituted outrageous, malicious and oppressive conduct on the part of the Defendant and exhibited wanton and reckless disregard of the probability of causing severe emotional distress to the Plaintiff.

9. The Plaintiff further alleges that as a proximate result of the Defendant's reckless, wanton, malicious, oppressive and outrageous conduct in the denial of the said claim, she has been caused to suffer the following injuries and damages: she has suffered severe emotional distress; she has suffered much embarrassment, humiliation, and sleeplessness; she has suffered emotionally, still so suffer, and will so suffer in the future; and her credit and reputation have been damaged.

WHEREFORE, the Plaintiff demands judgment against the Defendants in the sum of FIVE MILLION ($5,000,000.00) DOLLARS as compensatory and punitive damages.

THIRD CAUSE OF ACTION

1. The Plaintiff, Margaret W. Lavoie, realleges all of the allegations contained in paragraphs 1, 2, 3, 4, 5, 6 and 7 of the

Second Cause of Action and reincorporates the same by reference herein.

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8. The Plaintiff further alleges that the refusal of the Defendant to pay the claimed benefits in light of all of the evidence available to the Defendant, particularly in the form of the hospital records, nurse's notes and admitting physician's reports regarding the necessity of her treatment as an inpatient constituted a reckless and/or wilful and/or wanton breach of the implied duty to deal in good faith in its contractual relationships, and of the implied duty to exercise due care in the performance of its contractual obligations.

9. The Plaintiff further alleges that as a proximate result of the above described reckless, wilful and/or wanton conduct of the Defendant in tortiously breaching the implied duties of good faith in its dealings and of due care in the performance of its obligations under the contract, the Plaintiff sustained the injuries as set forth in paragraph nine of the Second Cause of Action, those injuries being set forth and incorporated by reference herein.

WHEREFORE, the Plaintiff demands judgment against the Defendants in the sum of FIVE MILLION ($5,000,000.00) DOLLARS as compensatory and punitive damages.

FOURTH CAUSE OF ACTION

1. The Plaintiff, Roger J. Lavoie, Sr., who is the husband of the Plaintiff, Margaret W. Lavoie, alleges that on, to-wit, February 3, 1977, the said Margaret W. Lavoie entered the Mobile Infirmary, Mobile, Alabama, to undergo a series of tests which had been prescribed by her physician, for which the Plaintiff Roger J. Lavoie, Sr., incurred a total charge from the Mobile Infirmary of Three Thousand Twenty-eight and 25/100 ($3,028.25) Dollars for treatment of his said wife between February 3 and February 26, 1977.

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2. The Plaintiff further alleges that at the time the said hospital expenses were incurred and for some period of time previous thereto, he was an insured beneficiary within the terms of a Group Policy of Health and Medical Insurance issued by the Defendant, Aetna Life and Casualty Company, Inc., and issued to the City of Mobile as policyholder and which was in full force and effect at the time the said expenses were incurred, the said City of Mobile having paid premiums to the Defendant, Aetna, for the Plaintiff's benefit.

3. The Plaintiff further alleges that the expenses incurred by him due to his said wife's hospitalization in the Mobile Infirmary during the above described period were expenses which the Defendant, Aetna, had contracted to pay and were under a duty to pay under the terms and conditions of the policy of insurance issued by the Defendant, Aetna, to the City of Mobile as policyholder.

4. The Plaintiff further alleges that the Defendant, Aetna, is a foreign corporation doing business in Mobile County, Alabama.

5. The Plaintiff further alleges that the Defendant, Aetna, did pay a portion of the total charge incurred by the Plaintiff as a result of his said wife's above described confinement, but that the Defendant, Aetna, has steadfastly refused the demands of the Plaintiff to pay the balance due on his account of One Thousand Six Hundred Fifty and 22/100 ($1,650.22) Dollars.

6. The Plaintiff further alleges that the refusal of the Defendant, Aetna, to pay the said benefits due under the contract of insurance constitutes a breach of the contract of insurance under which the Plaintiff is a beneficiary.

WHEREFORE, the Plaintiff demands judgment against the Defendants in the sum of ONE THOUSAND SIX HUNDRED AND FIFTY AND 22/100 ($1,650.22) DOLLARS plus costs and interest.

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FIFTH CAUSE OF ACTION

1. The Plaintiff, Roger J. Lavoie, Sr., realleges all of the allegations contained in Paragraphs 1, 2, 3, 4 and 5 of the Fourth Cause of Action and incorporates the same by reference herein.

6. The Plaintiff further alleges against the Defendant, Aetna, that subsequent to the initial denial of benefits by the Defendant on the grounds that the tests performed on the Plaintiff's wife, Margaret W. Lavoie, should have been incurred in an outpatient rather than an inpatient basis, and at the Defendant's request that a medical report from the admitting physician be supplied to the Defendant, the Plaintiff supplied the Defendant with medical reports from his said wife's admitting physician which recited the fact that at the time of the Plaintiff's wife's admission into the hospital, the controlled atmosphere of the hospital was necessary to carry out the required testing and observation of the Plaintiff's wife.

7. The Plaintiff further alleges that the steadfast refusal of the Defendant to pay the claimed benefits in light of all of the evidence available to the Defendant, particularly in the form of the hospital records, nursing notes and admitting physician's reports regarding the necessity of his wife's treatment as an inpatient, constituted outrageous, malicious and oppressive conduct on the part of the Defendant and exhibited wanton and reckless disregard of the probability of causing severe emotional distress to the Plaintiff.

8. The Plaintiff further alleges that as a proximate result of the Defendant's reckless, wanton, malicious, oppressive and outrageous conduct in the denial of the said claim, he has been caused to suffer the following injuries and damages: he has suffered

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severe emotional distress; he has suffered much embarrassment, humiliation and sleeplessness; he has suffered emo-

tionally, still so suffers, and will so suffer in the future; and his credit and reputation have been damaged.

WHEREFORE, the Plaintiff demands judgment against the Defendants in the sum of FIVE MILLION ($5,000,000.00) DOLLARS as compensatory and punitive damages.

SIXTH CAUSE OF ACTION

1. The Plaintiff, Roger J. Lavoie, Sr., realleges all of the allegations contained in Paragraphs 1, 2, 3, 4, 5 and 6 of the Fifth Cause of Action and incorporates the same by reference herein.

7. The Plaintiff further alleges that the refusal of the Defendant to pay the claimed benefits in light of all of the evidence available to the Defendant, particularly in the form of the hospital records, nurse's notes and admitting physician's reports regarding the necessity of his wife's treatment as an inpatient constituted a reckless and/or wilful faith in its contractual relationships, and of the implied duty to exercise due care in the performance of its contractual obligations.

8. The Plaintiff further alleges that as a proximate result of the above described reckless, wilful and/or wanton conduct of the Defendant in tortiously breaching the implied duties of good faith in its dealings and of due care in the performance of its obligations under the contract, the Plaintiff sustained the injuries and damages as set forth in Paragraph 8 of the Fifth Cause of Action those injuries and damages being set forth and reincorporated by reference herein.

WHEREFORE, the Plaintiff demands judgment against the Defendants in the sum of FIVE MILLION ($5,000,000.00) DOLLARS as compensatory and punitive damages.

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CUNNINGHAM, BOUNDS, BYRD, YANCE & CROWDER
Attorneys for Plaintiffs

BY_____
JOSEPH M. BROWN, JR.

Plaintiffs respectfully demand a trial by jury.

BY_____
JOSEPH M. BROWN, JR.

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IN THE CIRCUIT COURT OF MOBILE COUNTY, ALABAMA

Civil Action No. CV-78-001614

MARGARET W. LAVOIE, *et al.*,

Plaintiffs,

-VS-

AETNA LIFE & CASUALTY COMPANY, INC., *et al.*,

Defendants

FOURTH AMENDED COMPLAINT

Come the Plaintiffs in the above styled cause and amend the complaint filed heretofore in this action by adding a Seventh and Eighth Cause of Action as follows, the Plaintiffs expressly reincorporated all of the allegations contained in the most recent complaint filed heretofore in this action:

SEVENTH CAUSE OF ACTION

The Plaintiff, Margaret W. Lavoie, alleges against the Defendants as follows:

1. The Plaintiff realleges all of the allegations contained in paragraphs one, two, three, four, five and six of the First Cause of Action and incorporates the same by reference herein.

7. The Plaintiff further alleges that the Defendant, Aetna, acting by and through its agents, servants or employees, who were working in concert one with the other, did conspire to defraud the Plaintiff out of the benefits to which she was entitled by various acts of trickery and deception and by intentionally misleading statements made to the Plaintiff during the course of the various handlings of the claim of the Plaintiff for medical benefits on the respective occasions when the claim was submitted and later resubmitted on several occasions to

the Defendant's group claims office for approval of the said medical benefits.

8. The Plaintiff further alleges that as a proximate con-

[1]*

sequence of the above described conspiracy of the Defendants to defraud her out of the benefits to which she was entitled, she was caused to suffer the injuries and damages as set forth in paragraph nine of the Second Cause of Action, those injuries and damages being set forth and incorporated by reference herein.

WHEREFORE, the Plaintiff demands judgement against the Defendants in the sum of FIVE MILLION ($5,000,000.00) DOLLARS plus costs as compensatory and punitive damages.

EIGHTH CAUSE OF ACTION

The Plaintiff Roger J. Lavoie, Sr., alleges against the Defendants as follows:

1. The Plaintiff realleges all of the allegations contained in paragraphs one, two, three, four, five, six, seven and eight of the Seventh Cause of Action and incorporates the same by reference herein.

WHEREFORE, the Plaintiff demands judgement against the Defendants in the sum of FIVE MILLION ($5,000,000.00) DOLLARS plus costs as compensatory and punitive damages.

CUNNINGHAM, BOUNDS, BYRD,
YANCE & CROWDER
Attorneys for Plaintiffs

BY:_____
JOSEPH M. BROWN, JR.

Plaintiffs respectfully demand a trial by jury.

BY:_____
JOSEPH M. BROWN, JR.

*Page no. of record on third appeal of case to Supreme Court of Alabama.

AFFIDAVIT

This is to certify that the attached copy of Group Policy No. GC 321431 is a true and correct copy of the Group Insurance contract issued by the Aetna Life Insurance Company to City of Mobile.

AETNA LIFE INSURANCE COMPANY

By _____, Sr. Suit Supt.
John G. McTigue
Group Claim Department

State of Connecticut)
)ss:
County of Hartford)

On this 23d day of October, 1978, personally appeared John G. McTigue to me known to be the person who signed the foregoing statement, and acknowledged the same to be his free act and deed.

SEAL:

_____
Notary Public

My Commission Expires March 31, 1982

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*Page no. of record on third appeal of case to Supreme Court of Alabama.

AETNA LIFE INSURANCE COMPANY
HARTFORD, CONNECTICUT

(Herein called the Insurance Company)

Group Policy No.: GC-321431

Policy Delivered in: Alabama
(State or other Jurisdiction)

Policyholder: CITY OF MOBILE

Policy Signed: July 17, 1967

To Take Effect: February 1, 1967

This policy is a contract between the Policholder and the Insurance Company and shall be construed in accordance with the law of the jurisdiction in which it is delivered.

In consideration of the payment by the Policyholder of premiums in the amounts and at the times hereinafter provided, the Insurance Company hereby agrees with the Policyholder, subject to the terms appearing on this and the following pages of this policy (including, if any, the riders, endorsements, and amendments, to this policy which are signed by the Insurance Company), to pay benefits in accordance with the terms of this policy. The obligations and the rights of all persons under this policy shall be determined in accordance with the terms of this policy.

In witness whereof the Insurance Company has signed this policy at Hartford, Connecticut.

Secretary *President*

Registrar

GROUP INSURANCE POLICY

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* * * *

321431

Article II—BENEFITS (Continued)

EXCLUSIONS, LIMITATIONS, AND PROVISIONS APPLICABLE TO TITLE MMEB (Continued)

If, at any time, the Maximum Benefit under this Title is increased and if on the date of any such increase (each such date shall hereinafter be referred to as the "increase date") the covered family member is disabled, the Maximum Benefit of such family member shall, until he ceases to be disabled, be limited to the unused portion of the family member's Maximum Benefit as of the day immediately preceding such increase date.

Note: The term "disabled," as used in the preceding paragraph, means, with respect to the employee, that the employee is both disabled (i.e., ill or injured) and away from work, and, with respect to the dependent, that the dependent is confined, by reason of disease or injury, at home, in a hospital, or elsewhere or that the dependent has been confined in a hospital at any time during the thirty-one day period immediately preceding the increase date. An employee shall be deemed to have ceased to be disabled on the date the employee returns to work on a full-time basis. A dependent shall be deemed to have ceased to be disabled on the earlier to occur of

(a) the end of a thirty-one day period during which there has been no confinement of any kind, and

(b) the date the Insurance Company is furnished with evidence satisfactory to it that the dependent has completely recovered from all such diseases or injuries causing such confinement.

In the event a family member is not covered under this Title on the increase date solely because benefits aggregating the Maximum Benefit shall have been paid or accrued in respect of such family member prior to such increase date such family member shall again become covered under this Title on the increase date if he meets all of the following requirements on such date,

otherwise on the date he meets all of the following requirements:

(a) the employee makes written request to his Participant Employer for such insurance within thirty-one days following the increase date; and

(b) the family member is not "disabled," as defined above; and

(c) the employee is insured under this Title with respect to all other eligible family members.

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321431

Article II—BENEFITS (Continued)

TITLE MMEB—MAJOR MEDICAL EXPENSES BENEFITS (Continued)

Extension of Benefits

If insurance with respect to a family member terminates while he is totally disabled and before benefits aggregating his Maximum Benefit become payable with respect to him, any benefits provided under this Title for that family member, but for no other family member, will continue to be available as to expenses incurred during the uninterrupted continuance of such total disability but not beyond the period of twelve months immediately following such termination of insurance and in no event beyond the date the family member becomes insured under any other group policy, whether issued by the Insurance Company or any other insurer, for benefits of a type similar to that provided for in this Title. The words "totally disabled" and "total disability" mean that the family member, if an employee, is prevented, solely because of a non-occupational injury or non-occupational disease, from engaging in his regular or customary occupation and is performing no work of any kind for compensation or profit, or if a dependent, is prevented, solely because of a non-occupational injury or non-occupational disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

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321431

Article II—BENEFITS

EXCLUSIONS, LIMITATIONS, AND PROVISIONS APPLICABLE TO ALL TITLES UNDER ARTICLE II

Extension of Benefits: If insurance with respect to a family member under one or more of the Titles under Article II (except Titles ADDC, WBC, MMEB, CDEB, PEB, and AEB, if included in this policy) terminates while he is totally disabled, any benefit provided under such Title for that family member, but for no other family member, will continue to be available as to expenses incurred during the uninterrupted continuance of such total disability but not beyond a period of three months following the date such termination of insurance occurs. Expenses in respect of which benefits are payable under Title HEB, if included in this policy, will be deemed to be incurred within such three months period if the hospital confinement commenced within such period. The words "totally disabled" and "total disability" mean, for the purposes of this paragraph, that the family member, if an employee, is prevented, solely because of injury or disease, from engaging in his regular or customary occupation and is performing no work of any kind for compensation, or if a dependent, is prevented, solely because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

No insurance is afforded under any Title of Article II as to charges

(1) that would not have been made if no insurance existed or that no individual with respect to whom insurance under such Title relates is legally obliged to pay; or

(2) for services or suplies which are furnished or paid for, or with respect to which benefits are provided, under any law of a government (national or otherwise) by reason of the past or present service of any person in the armed forces of a government; or

(3) for services or supplies, other than those referred to in item (2) above, which are paid for, or with respect to which benefits are provided, under any law of a gov-

ernment (national or otherwise) except where such payments are made or such benefits are provided under a plan specifically established by a government for its own civilian employees and their dependents; or

(4) in connection with any hospital confinement or any surgical, medical, or other treatment, services, or supplies which are not recommended and approved by a physician who is attending the covered family member; or

(5) for care, treatment, services or supplies which are not necessary for the treatment of the injury or disease concerned nor to the extent that any charges for care, treatment, services or supplies are unreasonable; or

(6) caused or contributed to by, or as a consequence of, pregnancy or resulting childbirth, miscarriage or abortion; except to the extent, if any, that benefits are specifically provided therefor under the provisions of any title of Article II of this policy;

and before determining benefits under any Title, the amount of any such charges shall be deducted from the family member's expenses which are covered under such Title and from his Allowable Expenses (as hereinafter defined).

If any law of the jurisdiction in which this policy is delivered prohibits or restricts the application of item (2) or (3) above as to a facility owned or operated by such jurisdiction or by any of its political subdivisions, said items (2) and (3) shall be applicable only to the extent permitted by such law.

No benefits are payable under this policy to the extent that the provision of such benefits is prohibited by any applicable law of the jurisdiction in which the individual resides at the time the claim is incurred.

321431

Article II—BENEFITS (Continued)

EXCLUSIONS, LIMITATIONS AND PROVISIONS APPLICABLE TO ALL TITLES UNDER ARTICLE II (Continued)

No insurance is afforded under any Title of Article II as to charges for custodial care; and before determining benefits under any Title, the amount of any such charges shall be deducted from the family member's expenses which are covered under such Title and from his Allowable Expenses (as hereinafter defined).

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321431

Article II—BENEFITS (Continued)

EXCLUSIONS, LIMITATIONS, AND PROVISIONS APPLICABLE TO ALL TITLES UNDER ARTICLE II (Continued)

Provision For Co-ordination Of Benefits Under This Policy With Other Benefits

A. Benefits Subject To This Provision:

All of the benefits provided under this Article II (except those provided under Titles ADDC and WBC, if included) are subject to this provision.

B. Definitions

(1) "Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by (a) group insurance or any other arrangement of coverage for individuals in a group whether on an insured or uninsured basis or (b) automobile reparations (no-fault) insurance required under any law of a government and provided through arrangements other than those described in (a) but only to the extent of benefits required under such no-fault law.

The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

(2) "This Plan" means those portions of this policy which provide the benefits that are subject to this provision.

(3) "Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

(4) "Claim Determination Period" means calendar year, but if a person is not eligible for benefits under this Plan during all of a celandar year, then the Claim Determination Period for such person as to that year shall be the total period thereof during which he was eligible for benefits.

C. Effect on Benefits

(1) This provisioin shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such Claim Determination Perioid, the sum of

(a) the benefits that would be payable under this Plan in the absence of this provision, and

(b) the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision

would exceed such Allowable Expenses.

Article II—BENEFITS (Continued)

EXCLUSIONS, LIMITATIONS, AND PROVISIONS APPLICABLE TO ALL TITLES UNDER ARTICLE II (Continued)

Provision For Co-ordination Of Benefits Under This Policy With Other Benefits (Continued)

C. Effect on Benefits (Continued)

(2) As to any Claim Determination Period with respect to which this provisioin is applicable, the benefits that would be payable under this Plan in the absence of this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as provided in item (3) of this section C, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefor.

(3) If

(a) another Plan which is involved in item (2) of this section C and which contains a provision co-ordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and

(b) the rules set forth in item (4) of this section C would require this Plan to determine its benefits before such other Plan,

then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.

(4) For the purposes of item (3) of this section C, the rules establishing the order of benefit determination are:

(a) The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as a dependent;

(b) The benefits of a Plan which covers the person on whose expenses claim is based as a dependent of a male person shall be determined before the benefits of a Plan which covers such person as a dependent of a female person;

(c) When rules (a) and (b) do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time.

(5) When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

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Article II—BENEFITS (Continued)

EXCLUSIONS, LIMITATIONS, AND PROVISIONS APPLICABLE TO ALL TITLES UNDER ARTICLE II (Continued)

Provision For Co-ordination Of Benefits Under This Policy With Other Benefits (Continued)

D. Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other Plan, the Insurance Company may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any infor-

mation, with respect to any person, which the Insurance Company deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Insurance Company such information as may be necessary to implement this provision.

E. Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the Insurance Company shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the Insurance Company shall be fully discharged from liability under this Plan.

F. Right of Recovery

Whenever payments have been made by the Insurance Company with respect to Allowable Expenses in a total amount which is, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Insurance Company shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Insurance Company shall determine: any persons to or for or with respect to whom such payments were made, any other insurance companies, any other organizations.

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* * * *

Article IV—PREMIUMS

Section 1. Premium Rates

The premium rates are as follows, but are subject to change as hereinafter provided: The premium rates shown are for a period of one month.

Title ADDC—Premium per $1,000 of Principal Sum: $.06 (Currently subject to a 13% reduction)

	*Premium Per Employee**	
	Employee Coverage	*Dependent Coverage*
Title HEB	$4.83	$10.19
Title SEB	.94	2.94
Title IHMEB	.31	.52
Title LXEB	.53	.71
Title MMEB	.94	1.40

*(Currently subject to a 14% reduction)

Section 2. Premium Calculations and Experience Rating

The premium due under this policy on any premium-due date shall be the sum of the premium charges for the insurance provided under the Titles then forming a part of this policy. The premium charges for the insurance under any such Title shall be calculated at the Premium Rates specified above, subject to such reductions or increases as the Insurance Company shall determine to be warranted by experience or by reason of any change in factors bearing on the risk assumed. Each reduction or increase in any premium rate shall be made by written notification to the Policyholder by the Insurance Company.

No experience reduction or increase in premium rates shall become effective less than twelve months after the effective date of this policy.

As of the end of any policy year the Insurance Company may declare an experience credit in such amount as the Insurance Company shall determine. The amount of each experience credit declared by the Insurance Company shall be refunded to the Policyholder, or upon request by the Policyholder, a part or all of the experience credit shall be applied against the payment of any premium or premiums.

Article IV—PREMIUMS (Continued)

Section 2. Premium Calculations and Experience Rating (Continued)

If at any time the aggregate of employee contributions heretofore made for group insurance shall exceed the aggregate of premiums theretofore paid for group insurance (after giving effect to any experience credits allowed the Policyholder), such excess shall be applied by the Policyholder for the sole benefit of employees, but the Insurance Company shall not be obliged to see to the application of any such excess.

If premiums are payable monthly, any insurance becoming effective shall, except as hereafter provided, be charged for from the first day of the policy month coinciding with or next following the date the insurance takes effect, and premium charges for any insurance terminated shall cease as of the first day of the policy month coinciding with or next following the date the insurance terminates. If premiums are payable quarterly, semi-annually, or annually, premium charges or credits for a fraction of a premium-paying period required by the foregoing terms of this paragraph shall, except as hereinafter provided, be made on a pro-rata basis for the number of policy months between the date premium charges commence or cease and the end of the premium-paying period. If this policy is amended to provide additional insurance, or any increase in insurance, and if the effective date of such amendment is other than the first day of a premium-paying period, a pro-rata premium in respect of such insurance shall become due and payable as of such date, to cover the period beginning on that date and ending immediately prior to the commencement of the next premium-paying period.

Instead of the method of calculation of premiums above provided, premiums may be calculated by any method which produces approximately the same total amount of premiums and is mutually agreeable to the Insurance Company and the Policyholder.

Section 3. Premiums, How Payable

Premimiums shall be payable by the Policyholder in advance at the Home Office of the Insurance Company or to its authorized agent.

The first premium under this policy shall be due and payable as of the date of issue to cover the period beginning on that date and ending on the last day of the first policy month and thereafter premiums shall be due and payable on the first day of each policy month.

Section 4. Grace Period

A grace period of thirty-one days following the due-date shall be allowed the Policyholder for the payment of each premium.

[345]

THE STATE OF ALABAMA . . . . . JUDICIAL DEPARTMENT

THE SUPREME COURT OF ALABAMA

OCTOBER TERM, 1984-85

82-416 &
82-1152

AETNA LIFE & CASUALTY CO., INC.

VS.

MARGARET W. LAVOIE and ROGER J. LAVOIE, SR.

Appeals from Mobile Circuit Court

APPLICATION FOR REHEARING

The Appellant, Aetna Life & Casualty Company, Inc., through its undersigned counsel, hereby applies for Rehearing of the judgment of this Court entered December 7, 1984.

As grounds for said applications, the Appellant would show that the aforesaid opinion and judgment of this Cout erred in the following respects:

1. The majority improperly determined that the poverty of the plaintiff was relevant and material in this case.

2. The majority opionion relied on factual inaccuracies and omissions.

3. The majority improperly determined that the Appellant resorted to legal artifice to create a questions of fact.

4. The majority incorrectly relied on Dr. Swann's affidavit to support the conclusion that Dr. Swann never reviewed the letter reports from Mrs Lavoie's treating physician.

5. The majority improperly concluded that Dr. Swann first reviewed the medical records on April 28, 1977, as opposed to April 25, 1977.

6. The majority inproperly refused to remit grossly excessive punitive damages.

7. The majority incorrectly, without factual basis in the record, determined that Dr. Swann *never* reviewed either letter from Dr. Douglas.

8. The majority incorrectly applied the law and facts regarding the effect of the defendant's partial payment.

9. The majority has overruled over one hundred fifty years of legal precedence, i.e. that rule of law which precludes the trial judge from ruling on the credibility and weight of evidence received at trial.

RESPECTFULLY SUBMITTED:

SINTZ, PIKE, CAMPBELL & DUKE
Attorneys for Appellant
3763 Professional Parkway
Mobile, AL 36609

BY:_____
PETER V. SINTZ

BY:_____
WILLIAM M. CUNNINGHAM, JR.

CERTIFICATE OF SERVICE

I hereby certify that I have on this 20th day of December, 1984 served a copy of the foregoing pleading on counsel for the

Appellees to this proceeding by mailing a copy of same by United States mail, properly addressed and first class postage prepaid as follows:

Hon. Joseph M. Brown, Jr.
Post Office Box 66705
Mobile, AL 36660

PETER V. SINTZ

THE STATE OF ALABAMA . . . . . JUDICIAL DEPARTMENT

THE SUPREME COURT OF ALABAMA

OCTOBER TERM, 1984-85

82-416 &
82-1152

AETNA LIFE INSURANCE COMPANY
VS.
MARGARET W. LAVOIE and ROGER J. LAVOIE, SR.

Appeals from Mobile Circuit Court

AMENDMENT TO APPLICATION FOR REHEARING

The Appellant, Aetna Life Insurance Company, improperly referred to as Aetna Life & Casualty Company, Inc., in the Court's Opinion of December 7, 1984, through its undersigned

counsel, hereby amends its Application for Rehearing by adding the following ground:

10. The errors committed in the majority opinion have resulted in a violation of the Appellant's rights under the Constitution of the United States of America.

Respectfully submitted.

PETER V. SINTZ

WILLIAM M. CUNNINGHAM, JR.

OF COUNSEL:

Sintz, Pike, Campbell & Duke
3763 Professional Parkway
Mobile, Alabama, 36609

CERTIFICATION OF SERVICE

I do hereby certify that I have on this 28 day of December, 1984, served a copy of the foregoing pleading on counsel for all parties to this proceeding by mailing same by United States mail, properly addressed and first class postage prepaid.

PETER V. SINTZ

Hon. Joseph M. Brown, Jr.
Post Office Box 66705
Mobile, Alabama 36660

JA-53

IN THE

SUPREME COURT OF ALABAMA

No. 82-426

AETNA LIFE & CASUALTY CO., INC. a corporation,
Appellant,

-VS-

MARGARET W. LAVOIE AND ROGER J. LAVOIE, SR.,
Appellees.

Appeal From the Circuit Court Thirteenth Judicial Circuit of Mobile County, Alabama

---

BRIEF OF APPELLEES

CUNNINGHAM, BOUNDS, YANCE, CROWDER AND BROWN
POST OFFICE BOX 66705
MOBILE, ALABAMA 36660

ORAL ARGUMENT REQUESTED

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STATEMENT OF THE CASE

This is the third appeal of this case. On the previous appeals of the case, the plaintiff had (1) been dismissed on the pleadings under a 12(b)(6) motion filed by the defendant, Aetna, and, (2) been dismissed as a result of the Trial Court's granting of the defendant's motion for summary judgment [see *Lavoie vs. Aetna Life & Casualty Co., Inc.*, 374 So.2d 310 (Ala. 1979); *Lavoie vs. Aetna Life & Casualty Co., Inc.*, 405 So.2d 17 (Ala. 1981)]. On both occasions, this court reversed the judgment of the Trial Court and remanded the case to the Trial Court for further proceedings.

The case was tried to a jury in the Mobile County Circuit Court on November 1-4, 1982 before the Honorable Michael Zoghby. The case was submitted to the jury on counts alleging breach of contract and bad faith refusal to pay on the part of the defendant. (R. 456).

At the close of all the evidence, the Trial Court denied the defendant's motion for directed verdict on the bad faith claim, allowing the case to go to the jury on both the contract count and the bad faith count. (R. 561; see court's charge at R. 570, et seq.).

It was stipulated, prior to the submission of the case to the jury, that the maximum amount at issue on the contract claim was $1,650.22. (R. 566).

After deliberation, the jury returned a verdict on November 4, 1982 in the sum of $3,501,650.22. (R. 599).

Thereafter, on November 17, 1982, the defendant filed a motion for judgment notwithstanding the verdict, or, in the alternative, remittitur, or, in the alternative, for a new trial. (TR. 58). It is respectfully noted for the Supreme Court that the defendant's motion for new trial:

> a. assigns absolutely no trial error committed on the part of the trial judge during his conduct of the trial itself or in the court's charge to the jury;

b. raises absolutely no issue with regard to assignment number 4 concerning the wealth or poverty of a party in the lawsuit (see page iii of defendant's brief and argument);

c. raises only the issues of the sufficiency of the proof offered by the plaintiff at the trial of the case and the alleged excessiveness of the verdict in this case.

The post-trial motion noted hereinabove was submitted to the Trial Court on December 17, 1982. (TR. 63). Judge Zoghby denied all of the defendant's post-trial motions, including the motion for remittitur, on January 28, 1983. (TR. 64, 70). Thereafter, on February 10, 1983, the defendant filed its notice of appeal. (TR. 72).

STANDARD FOR REVIEW

"In Alabama, the verdict of a jury is presumed correct and this presumption of correctness of the jury's verdict is strengthened once the Trial Court has entertained and denied a motion for a new trial." *Cox vs. Herrington*, 416 So.2d 968 (Ala. 1982); *Cooper vs. Peturis*, 384 So.2d 1087 (Ala. 1980).

> "The power to set aside verdicts has been generally regarded in this country as inherent in courts organized upon the principals of common law, though in some states it is regulated by statute, enumerating the grounds upon which a motion for a new trial may be made . . . But, in exercising the power, the court should be careful not to infringe *the right of trial by jury*, and should bear in mind, that it is their exclusive province to determine the credibility of witnesses, to weigh the testimony, and find the facts. Being selected for their impartiality and qualification to judge facts, and unanimity of opinion and conclusion being required, their *verdicts are presumed to be correct*. It has been said that no ground of new trial is more carefully scrutinized or more rigidly limited, than the verdict is against the evidence - Hillard on new Trials, 339. The power should be exercised, *only*, when it affir-

matively appears that the substantial ends of justice require the examination of the facts by another jury. *If these be the principles by which the Trial Court should be governed, they apply with much more force to the exercise of the power by an Appellate Court.* When the presiding judge refuses to grant a new trial, the presumption in favor of the correctness of the verdict is thereby strengthened . . ." *Cobb vs. Malone and Collins*, 92 Ala. at 633, 9 So. at 739 (1890) (Emphasis added).

"In reviewing the correctness of a jury verdict, this court must review the record in a light most favorable to the appellee." *Cooper vs. Peturis*, 384 So.2d at 1088.

STATEMENT OF THE FACTS

The plaintiffs, Margaret W. and Roger J. Lavoie, Sr., are husband and wife. On February 3, 1977, Mrs. Lavoie, an insured beneficiary within the terms of a group policy of health and medical insurance issued by the defendant, Aetna, entered the Mobile Infirmary to undergo a series of tests which had been prescribed by her physician, Dr. John B. Douglas. (R. 33, 56-57). Mr. Lavoie, a totally disabled, retired police officer with the City of Mobile, was likewise an insured beneficiary under the same policy, which had been issued to the City of Mobile as the policy holder. (R. 32, 56-57). The policy was in full force and effect at the time of Mrs. Lavoie's hospitalization. (R. 57, 109). Incident to Mrs. Lavoie's hospitalization, between February 3 and February 26, 1977, the plaintiffs incurred a total charge from the Mobile Infirmary of some $3,028.25 (see Plaintiffs' Exhibits 1 and 2, respectively at TR. 79-80). Aetna paid a portion of the total charges incurred by the plaintiffs prior to the institution of litigation, and it was stipulated by counsel that the maximum amount of the benefits in question under the contract claim in this case was a total of some $1,650.22 (see stipulation at R. 566).

For purposes of clarification, the court should carefully note that the exhibits marked Plaintiffs' Exhibit 3-5 at the trial of the case and appearing in this transcript are defined as follows:

*** PLAINTIFFS' EXHIBIT 3 ***

AETNA'S *HOME OFFICE ("HO") FILE FROM THE HARTFORD, HOME OFFICE*

(Identified at R. 114 by Ms. Brenda Harris, an Aetna senior claims processor, and appearing at TR. 81-100).

*** PLAINTIFFS' EXHIBITS 4 AND 5 ***

AETNA'S *MOBILE, ALABAMA FILE*

(Identified by Ms. Harris at R. 115). (Plaintiffs' Exhibit 4 appears in the record at TR. 101-132. Plaintiffs' Exhibit 5 appears in the record at TR. 133-167).

It is important for the court to recognize that the exhibits identified hereinabove originated from separate files maintained by Aetna in their Hartford and Mobile Claims Offices, respectively. These documents are Aetna's own files maintained by them during the course of the handling of Mrs. Lavoie's claim. The documents are Aetna's. The places where certain documents appear *and fail to appear* is critical to the bad faith which occurred in this case.

THE SUFFICIENCY OF THE EVIDENCE
PART I

Brenda Harris, an Aetna senior claims processor in Mobile, Alabama with 12 years experience in claims handling, was the first Aetna employee to examine the Lavoie hospitalization when the bill came in and was primarily responsible for the handling of Mrs. Lavoie's claim in the Mobile office. (R. 73-77, 88). Ms. Harris testified that Mrs. Lavoie's admitting diagnosis, ulcerative colitis, would have qualified her for coverage under the group medical policy that had been underwritten by Aetna, and that the policy itself was admittedly in full force and effect at the time of the admission to the Mobile Infirmary. (R. 109). The only reason for denial of the claim submitted by the Lavoies was set forth in the letter dated June 3, 1977 (R. 110-11; TR. 123).

Prior to this, on April 5, 1977, Brenda Harris, via inter-office communication dated April 5, 1977 and found at TR. 126, forwarded certain medical records to Jean Becker, the Home Office senior claims examiner in Hartford, for review. The records submitted to the Home Office were identified by Dr. Bernard Swan, a member of the Home Office Medical Department (and the only physician who ever reviewed the Lavoie claim for Aetna prior to its denial) as being the admitting sheet diagnosis, the admission history and physical, the doctor's orders, the discharge summary and extraneous information such as lab reports and "things like that." (R. 188-189. 476). The nurses' notes, which Dr. Swan volunteered were "an integral part of the chart", were not supplied at that time and were not obtained until April of 1978, a year later. (R. 191, 170. TR. 111). Ms. Harris, the senior claims adjustor from Mobile, while acknowledging that the nurses' notes were not a part of the information originally sent to the Home Office at the time of the first denial, testified that the significance of the nurses' notes was in the fact that they contained daily information on what was done to the patient, what medications were administered to the patient, and whether or not a patient was experiencing pain or physical illness on a given particular date. (R. 148-149). Tom Hutton, presently an assistant superintendent in the Claim Department and a senior claims examiner at the time of his review of the Lavoie file in 1977, likewise testified that he considered the nurses' notes "to be a significant portion of any medical file . . . much more so from a physician's standpoint than a nurses' standpoint." (R. 460, 485-486). The patient's progress notes were also omitted from the information which was sent to the Home Office during the first review of the Lavoie claim (see Harris at R. 152). Mr. Hutton likewise acknowledged the significance of the patient's progress notes in a hospital file, and noted that, procedurally, if he saw certain of the entries that were actually on Mrs. Lavoie's progress chart during his review of a claim he would, recognizing that he is not medically qualified to make a decision as to whether a person's hospitalization would be reasonable in light of such information, go first through his Medical Department for a medical

doctor's review prior to making any denial of that claim. (R. 486-489).

With this answer in mind, the court should note carefully that there were a total of *four reviews and four separate denials of the Lavoie claim by the Aetna Home Office claims staff.* At *no time* did Aetna *ever* obtain Mrs. Lavoie's progress records and progress notes during their respective reviews and denials of the subject claim (compare carefully Aetna's Mobile Office file and Aetna's Home Office file - Plaintiffs' Exhibits 3-5 at TR. 81-167 - with the actual subpoenaed hospital records from Mobile Infirmary - Plaintiffs' Exhibit 6 at TR. 168-239 - and especially the *progress records themselves* at TR. 183-185).

Subsequent to the submission of the Lavoie material to the Home Office of Aetna, the Home Office responded on *April 27, 1977* with directions to the Mobile office to deny payment for the room and board charges as well as for certain tests that had been administered to Mrs. Lavoie during her hospitalization. (TR. 85). This document recited that the file had been reviewed with:

> "a member of the Medical Department . . ."

and stated further that:

> "on the basis of *limited* information submitted, this confinement does not appear to have been medically necessary. We feel this patient *could* have been evaluated and treated on an out patient basis." (Emphasis added) (TR. 85).

In addition to the denial of in-patient room and board charges, the April 27, 1977 inter-office communication (IOC) also noted that three tests - the CAT scan, the EEG, and the EKG - that were administered during the confinement were also being denied, purportedly because the procedures were not "usual and customary for the diagnoses given." (R. 85)

It is important to note that, according to the testimony, the Home Office "Medical Department" of Aetna was purportedly

the primary precipitating factor in the denial of the Lavoie claim (see entire testimony of Dr. Swan and Jean Becker at R. 187 et seq. and R. 540 et seq.). Indeed, Ms. Becker noted that, in her experience as a group claims representative in the field, the procedure for handling such group medical claims was to refer them to the senior claims examiner at the Home Office who in turn would refer the claim to "the medical department." (R. 541-542). The senior claims examiner in the local office would have no direct contact with the "medical department." (R. 155, 541).

The obvious reason for having the "Medical Department" of the Home Office as the final authority in deciding whether to pay or deny in-patient hospital claims was shown in the testimony of Mr. Hutton and Dr. Swan. Under cross-examination, Mr. Hutton admitted that he was not medically qualified to render an opinion on medical matters and "that's why we have our medical department." (R. 474). Dr. Swan testified that he, as an associate medical director, works in the claim department and reviews "complicated problems *which require a medical opinion.*" (R. 187).

Thus, with the "Home Office Medical Department" being the primary factor in the denial of the Lavoie claim, it is necessary to define from the evidence exactly what the "Home Office Medical Department" consisted of. The term itself seems to be self-defining, and would appear to most people to mean exactly what it says, i.e., a department consisting of medical doctors assigned to the review of "complicated medical problems which require a medical opinion." (R. 187). However, due to some rather interesting developments during the discovery phase of this trial, and Aetna's attempts to explain their way out of glaring inconsistencies at trial, a more exacting examination of this term is called for.

Perhaps the most revealing document in the Aetna file in this regard is the April 27, 1977 inter-office communication from Jean Becker to Brenda Harris. (TR. 85). There, Ms. Becker, the senior claims examiner in Hartford, references review of

the subject file "with a member of the Medical Department." Obviously, Ms. Becker, as a part of the "claims staff", considered the "Medical Department" to be an entity of which she was not a part. The reference to "a member of the Medical Department" is obviously a reference to Dr. Swan, and this fact is borne out by Dr. Swan's own testimony. (R. 187 et seq.). Furthermore, Ms. Becker's own testimony bears out the fact that her reference to the "Medical Department" was a direct reference to "the doctor." (R. 550). Clearly, Tom Hutton, the senior analyst in Hartford, according to Ms. Becker, was not a member of the "Medical Department." (R. 550).

Likewise, Dr. Swan testified that the "Claim Medical Department" was comprised of six physicians. (R. 188). Again from the testimony of Ms. Becker, we find that it was the customary procedure at Aetna for the various regional claims offices to refer claims to the senior examiners in the Home Office who in turn referred the claims to the "Medical Department" for review (see testimony of Dr. Swan at R. 187, et seq.).

The court will also note the testimony of Ms. Harris at R. 91-93 where she acknowledges her desposition testimony (*given in January, 1980*) which unequivocably drew a distinction between Tom Hutton, the senior claims examiner at the Home Office, and the "Home Office Medical Department." (R. 91-92). Ms. Harris admitted at trial that not one time in her entire deposition did she ever tell plaintiffs' counsel that Tom Hutton and the "Medical Department" at Hartford were one and the same thing to her. (R. 92). Ms. Harris further acknowledged her deposition testimony as containing the following exchange:

> "Q: Outside of a direct inquiry from the Mobile office to the medical department of Aetna in Hartford, would anyone else have been involved in the denial of this claim?
>
> A: Now, the medical, the Mobile office *does not go directly to the medical department.* We go to our claims examiner, which is who we went to in this case." (Emphasis added).

(R. 93).

At R. 99 the following exchange took place between plaintiffs' counsel and Ms. Harris:

> "Q: Do you recognize the medical department as being *physicians*, don't you?
>
> A: I do now, yes, sir.
>
> Q: No ma'am, no. At the time you gave this deposition before you gave your affidavit, at the time you gave your deposition.
>
> A: At the time I gave my deposition I did, yes, sir.
>
> Q: O.k. and before you gave the affidavit, right?
>
> A: Right."

(Emphasis added).

With these excerpts for the term "Medical Department" as a basic, definitional premise, it is interesting to note the affidavit of Brenda Gail Harris which was filed by the defendant, Aetna, in support of its initial motion for summary judgment (see Plaintiffs' Exhibit 7 at TR. 240). This affidavit was read into evidence at R. 145. It will be noted that the affidavit itself was dated February 28, 1980, some thirty-five days after Ms. Harris' deposition was taken. (R. 144). Although Ms. Harris acknowledged that she had had no problem at all in January of 1980, when her deposition was taken in this case, with distinguishing "claims examiners" from the "Medical Department" of Aetna, she apparently developed quite a bit of difficulty by February 28, 1980 when her affidavit was given. (R. 144). In that sworn affidavit, Ms. Harris preliminarily remarks that:

> "I understand that an ambiguity may exist concerning my letter of December 23, 1977, to Thomas J. Stein. I stated in that letter that I had again checked with our Medical Department on this matter and they have advised that

based on the information available to us, we must continue to deny benefits for the room and board." (TR. 240).

Thereafter, in the same affidavit, Ms. Harris conveniently notes that she "customarily" refers to the senior claims examiner in Hartford as "our Medical Department" thus attempting to state under oath that now (February 28, 1980), some thirty-five days after her deposition was taken wherein she clearly, definitively and voluntarily distinguished between "claims examiners" and "Medical Department", she uses the term "Medical Department" interchangeably to connote senior claims examiners and the medical doctors in Hartford. It is respectfully submitted that this affidavit was nothing whatsoever more than a futile attempt by Aetna to cover up a glaring inconsistency and, indeed, a fraud committed upon the Lavoies. It marks merely one in a long series of attempts by the defendant, Aetna, to explain away and cover up several actual acts of fraud, conspiracy and direct lying that had been perpetrated upon the Lavoies during the course of Aetna's handling of the claim. The jury could, and rightfully did, arrive at such a conclusion based upon the following additional evidence taken at the trial.

PART II

On November 4, 1977, Dr. John Douglas, Mrs. Lavoie's treating physician, wrote a very detailed medical report to Thomas J. Stein, Mrs. Lavoie's attorney at that time, explaining with particularity exactly why Mrs. Lavoie required a twenty-three day period of confinement and why the tests that were denied by Aetna were relevant and necessary for her treatment at the time they were prescribed (see TR. 118-120). Ms. Harris received Dr. Douglas' letter as an enclosure in a letter from attorney Stein to Aetna dated November 8, 1977 (see TR. 118-119). The court will especially note the handwriting which appears at TR. 118 on the face of attorney Stein's letter to Aetna. This handwriting, it is respectfully submitted, is reflective of the exact conversation which occurred between Ms. Harris and Tom Hutton, the senior claims examiner at

Hartford, when she called him on November 9, 1977. That telephone conversation, as testified by Ms. Harris, revealed the following: Ms. Harris called Mr. Hutton on November 9, 1977 telling him that she had additional information concerning the Lavoie file. (R. 156). Prior to that date she had had no dealings with him on this particular file. (R. 156). To the best that she recalled, Mr. Hutton himself answered his own private line on that date. (R. 156). She informed him at that time that she had some additional information. (R. 157). After briefing him over the phone as to what the file was about, she read the letter from the attorney *and from Dr. Douglas*. (R. 157). After she read the doctor's letter to him, without repeating any portion of the letter, with *no medical doctor on the telephone with him*, and having read the letter to him one time and one only, Mr. Hutton, *admittedly unqualified to render a medical decision* (see closely R. 473-474), instructed Ms. Harris to:

> "Maintain the denial. *If they act like they are going to file suit, send it back to me.*"

(R. 156-159) (Emphasis added)

Ms. Harris then wrote attorney Stein via letter dated November 14, 1977 maintaining the denial and implying the need for more information. (R. 160, TR. 117). Responding, attorney Stein again wrote Aetna on December 19, 1977 with yet another report from Dr. Douglas attempting to answer the insurer's questions regarding the treatment he rendered to Mrs. Lavoie. (R. 164, TR. 115-116). The next day, December 20, 1977, Ms. Harris again called Mr. Hutton. Once again, she dialed his direct number, and Mr. Hutton picked up the phone. Mr. Hutton did not get any medical doctor on the telephone with him at that time either. (R. 164). No one else was on the phone other than the two of them. (R. 164). At that time, she read Mr. Hutton the letter from Dr. Douglas, again reading it only one time, and repeating nothing to him. (R. 165). After reading the letter to him, Mr. Hutton, the *medically unqualified* claims adjustor from Hartford, with no further medical information, no consultation with any physician, and with-

out even so much as the nurses' notes or progress notes in front of him at that time, directed her to continue denying the benefits based on the information available, and directed her to write the denial letter of December 23, 1977. (R. 165, 473-474, 476, 485). In response to those directions from Mr. Hutton, Ms. Harris wrote to Mr. Stein, the lawyer representing the Lavoies, on December 23, 1977 telling the Lavoies:

> "I have again checked with our Medical Department on this matter, and they have advised that based on the information available to us, we must continue to deny any benefits for the room and board." (R. 165, TR. 114).

This is in the face of two medical reports indicating that Mrs. Lavoie was bleeding from the rectum, had flight of ideation and noted personality changes. The reports state that hospitalization was necessary to rule out organic and abdominal disease and also organic intracranial disease. (R. 252, 253).

When this letter was written to the Lavoies, directly implying and representing to them that *both* of Dr. Douglas' medical reports had been reviewed by medical doctors hired by Aetna for purposes of review of such claims, both Ms. Harris and Mr. Hutton nonetheless acknowledged that absolutely no medical doctor had ever reviewed either one of the two medical reports that had been submitted to Aetna by the Lavoies in hopes of having the claim approved and paid. (R. 165, 474-485).

It is respectfully submitted that the above referenced testimony, trial material and exhibits, reflects clearly that on two of the four separate and distinct denials of the Lavoie claim, Aetna literally violated all of their recognized principles and procedures for properly handling such claims - deliberately bypassing the Medical Department who was the only source of medically qualified information available to Aetna - and then deliberately, intentionally and recklessly representing to the Lavoies that their file had been reviewed by a "member of the Medical Department." Clearly the inference which can be drawn from this deliberate intentional, fraudulent and conspiratorial misconduct on the part of Aetna's claims adjustors is

that they, at every opportunity, attempted to run the Lavoies off with intentional misrepresentations that the claim had been reviewed by a "member of the Medical Department" while the truth was that it had never been reviewed on those two distinct submissions by any person who was medically qualified to render such a decision.

Bearing in mind Dr. Swan's recitation of the importance of having an actual member of the Medical Department—a physician—as the one to pass judgment on "complicated problems which require a medical opinion" (Dr. Swan at R. 187), Ms. Harris nonetheless admitted that, although she had written the Lovoies' attorney on December 23, 1977 reciting as fact that she had "again checked" with the "Medical Department" in regard to Dr. Douglas' letters, in actuality, she had, as of December 23, 1977, consulted *no* member of the Medical Department with regard to either of Dr. Douglas' letters and knew that to be a fact when she wrote the December 23, 1977 letter to Mr. Stein. (R. 164-165).

The significance of Dr. Douglas' medical reports was noted by both Ms. Harris and Dr. Swan. Ms. Harris testified that she recognized the importance of a treating physician's report to their Medical Department and responded to questioning along this line as follows:

> "Q: What is the importance of a doctor's report to the Medical Department?
>
> A: The Medical Department *has to* base their decision on what the doctor informs them.
>
> Q: And that's a hard and fast rule, isn't it?
>
> A: Yes, sir.
>
> Q: O.k., and the Medical Department has to review that doctor's report, isn't that right?
>
> A: Yes, sir.
>
> Q: No exceptions to that to your knowledge?

A: Not to my knowledge.

Q: You know that Mr. Hutton is not a medical doctor, don't you?

A: Yes, sir.

Q: Did you know it at the time that you called him on November 9, 1977?

A: I knew that he was not a doctor, yes.

Q: You knew that he was not a trained medical physician, correct?

A: Yes, sir."

(R. 155) (Emphasis added).

Likewise, Dr. Swan responded to questions concerning the significance of the doctor's medical reports. As noted hereinabove, Dr. Swan's job at Aetna's Home Office Medical Department was to "review complicated problems which *require* a medical opinion." (R. 187) (Emphasis added). Dr. Swan went on to volunteer the following under questioning by Aetna's own counsel:

"Q: Did you consider Dr. Douglas' letter?

A: Yes. I was thumbing through it to try—I was interested in reviewing the letter, whether that's responsive to your question.

Q: Yes, I was going to ask you. Did you pay attention to his letter? Did you read it?

A: Yes, I did. I think the *most important bit of information* we like to get in such cases is a narrative report from the treating physician. It's the *most logical source of information.*"

(R. 199) (Emphasis added).

PART III

The next aspect of Aetna's intentional and fraudulent efforts to deceive the Lovies revolved around the initial handling and denial of the Lavoie claim. It will be recalled from the matters set forth hereinabove that the initial request by the Mobile Office to The Hartford Group Claims Office for a review of the Lavoie file was made on April 5, 1977 (TR. 88), and The Hartford Claims Office responded on April 27, 1977 with its initial denial, Ms. Becker reciting therein that "this file has been reviewed with a member of the Medical Department." (TR. 124). However, a closer review of the evidence itself indicates that Dr. Swan, the only member of the Medical Department of Aetna who ever reviewed the Lavoie file, did *not* review the file material and records until April *28*, 1977, one day *after* the original denial was sent to Mobile (see TR. 87 and testimony of Tom Hutton at R. 495). Dr. Swan's own handwritten notes found in the Home Office file at TR. 87 clearly show that the first day he ever worked on the file was April 28, 1977. It must be borne in mind that Dr. Swan worked in the Group Claims Office on only one day per week. (R. 187). An examination of Plaintiffs' Exhibit 9, a 1977 calendar, indicates that April 28, 1977 fell on a Thursday. (TR. 245). So as to alleviate any question about the date on which Dr. Swan first reviewed the Lavoie file, counsel for plaintiff asked Mr. Hutton himself, who, as the claims analyst at Aetna for several years, was obviously familiar with Dr. Swan's handwriting to read from the above-referenced handwritten notes of Dr. Swan found at TR. 87. From that page, containing handwriting of both Ms. Becker and Dr. Swan, Mr. Hutton stated the date on the page in Dr. Swan's own handwriting is "4-28-77." (R. 495).

To further solidify plaintiffs' contention that the first day Dr. Swan ever looked at the Lavoie records was April 28, 1977, the court should note the handwritten memo of Mr. R. E. Mann, another Aetna senior claims processor who reviewed the file on July 25, 1978. (TR. 86). At sub-paragraph (b) of the section labeled "Comments", Mr. Mann notes that "(w)e reviewed *on 4/28/77* and denied coverage of some charges. . ." Obviously,

Mr. Mann's notation is in reference to Dr. Swan's handwritten notes dated 4-28-77 and located at TR. 87. This notation comes from a man that Dr. Swan himself recognized as having been in The Hartford Claims Office for several years and who was intimately familiar with Dr. Swan's work, having worked "a lot more than fifty claims per year during those years of his association with Mr. Mann. (R. 377-379). Even Ms. Becker, the only witness who testified live for Aetna regarding this critical date, admitted under cross-examination that "there was initially some confusion in my mind about two or three months ago when Mr. Sintz first asked me what the date was on that particular piece of paper." (R. 555). Obviously, two to three months before trial, after this case had been submitted to the Supreme Court on appeal on two previous occasions where the critical nature of this particular date had been manifest, the jury could rightfully conclude that Ms. Becker's testimony that the "28" was a "25" was a result of the fact that Aetna very well *knew* that her testimony to the contrary would be a bald-faced admission of the bad faith which occurred in this case. (R. 555).

The court should also carefully note on this issue *TR. 84*, another page acknowledged by Dr. Swan as his handwriting. At the end of the first paragraph on that page, the court will note the figures (305.9). A comparison of the "5" located at TR. 84 with what Aetna would have this court and the jury believe was a "5" located at TR. 87 should leave no doubt that the jury, like Mr. Hutton and Mr. Mann, rightfully concluded that Dr. Swan's review of this file had indeed been made on April 28, 1977, *the day after the denial had been rendered by Jean Becker.* The court is encouraged to review the number in question to see just how unbelievable Aetna's story is—"Oh what a tangled web we weave. ."

Viewing this evidence most favorably to the plaintiffs, the jury could rightfully conclude from the above that the tail was wagging the dog at Aetna's Home Office, with senior claims adjustors writing final denials and then later going to the medical staff for rubber stamp approval of their already-rendered decisions, all in violation of Aetna's own in-house pro-

cedure which required that medical claims be denied by a medical doctor. Bear in mind that Dr. Swan's own testimony, supra, indicated that he was contacted only on *complex cases requiring a medical opinion.* (R. 187). Yet the denial had already been made on this "complex case" without any medical opinion whatsoever when the initial denial was made on April 27, 1977.

From a legal standpoint, the above is extremely significant in that it is conclusive evidence that, at the time the first of the four denials was made of the Lavoies' claim, Aetna had *no legal justification for denial of the claim at all,* having established by their own testimony that a medical opinion is required in order to properly deny such a claim, and the evidence clearly and convincingly showing that such a medical opinion was *not obtained* prior to the denial itself having been issued.

Still further evidence of the tail wagging the dog in this matter comes from yet a closer review of Mr. Mann's above-referenced handwritten summary of the Home Office's fourth review of the Lavoie file, and a comparison of it with Dr. Swan's testimony on this point (see again TR. 86). A review of Mr. Mann's handwritten notes at TR. 86 will reveal that absolutely *no* mention is ever made by Mr. Mann of any new consultation with a physician in the Aetna Medical Department on the basis of the newly submitted information—the nurses' notes. Yet, without more, and *on July 25, 1978,* Mr. Mann has rendered his own opinion that the denial should be maintained. According to Dr. Swan, three days later—July 28, 1978—is the first time he ever looked at the newly submitted nurses' notes on this particular review of the file. (R. 210-212). Plaintiffs' Exhibit 24, which Dr. Swan acknowledged in his deposition was his own copy of the handwritten notes which he made on his second review, and which defense counsel diligently sought to keep out of evidence, clearly notes that Dr. Swan's review had taken place on July 28, 1978. (TR. 248). Even though Dr. Swan's review of 7-28-78 coincides with Mr. Mann's typewritten July 28, 1978 inter-office communication to Alice Murphy in Mobile (TR. 82), a comparison of the inter-office communication itself

with the handwritten notes of Mr. Mann and Dr. Swan shows without question that the denial itself is a mirror of Mr. Mann's opinions formulated on July 25, 1978 and not at all of Dr. Swan's, formulated some three days later (compare TR. 82 with TR. 84, 248 and 86).

It is also noted at this point that the July, 1978 calendar, admitted as Plaintiffs' Exhibit 10 and located at TR. 246, will reveal that July 28, 1978 fell on a Friday. It is inescapable that both the dates of April 28, 1977 and July 28, 1978 were of critical importance to the plaintiffs' proof of bad faith which occurred in this case. It is likewise imminently apparent that all of the data and arguments which plaintiffs advanced at the trial of this case had been advanced in the brief of the Appellant filed in this same action which was filed in the Supreme Court of Alabama on January 13, 1981. At no time did Aetna ever attempt to explain away these obvious inconsistencies by some direct testimony in regard to the day of the week that Dr. Swan worked in the Medical Department. Both Dr. Swan and Mr. Mann were conspicuously absent from the trial fo this case. There being no explanation at all from Aetna with regard to these glaring inconsistencies, the jury could, and rightfully did, conclude that there was no explanation for the inconsistencies, and that, indeed, the tail *was* wagging the dog at Aetna.

PART IV

For future reference in this brief on what will be evidence of yet another fraud of Aetna in this matter, the court should note at this point the specific absence in Mr. Mann's 7-25-78 handwritten review and in his July 28, 1978 IOC (inter-office communication) of any reference at all to either of Dr. Douglas' reports generated in November and December of 1977, respectively. (TR. 82, 86). Apparently, neither of these "most important" (R. 199) medical reports were reviewed in making the July, 1978 denial, yet it will be seen, infra, that Aetna now contends that July, 1978 is the first and only time Dr. Douglas' reports were ever reviewed by a member of the Medical Department prior to the filing of this lawsuit.

Mr. Hutton did not consider himself, as a senior claims adjustor, qualified to render a medical opinion. (R. 474). "That's why we have our Medical Department." (R. 474). Dr. Swan was consulted on "complicated problems which *require* a medical opinion." (R. 187). Ms. Harris stated unequivocably that "the Medical Department has to base their decision on what a doctor informs them (in his doctor's report)" and that this was a hard and fast rule at Aetna with no exceptions. (R. 155). Indeed, a review of the documents generated at Aetna note the significance of and necessity for the Medical Department's review by a statement in virtually every document generated by the Claims Department that "our Home Office medical staff has again review this claim."

Thus, the internal standard and procedure for properly reviewing claims having been established by Aetna itself, the jury could rightfully conclude that the Aetna *claims staff* was intentionally and repeatedly engaged in the violation of its own standards and procedures via making medical decisions on "complicated problems". rendering their denials, and then on some, but not all, occasions seeking support from the medical staff on the basis of "the limited information available" (see testimony of Brenda Harris, Tom Hutton, Dr. Swan and the numerous documents reflected in Plaintiffs' Exhibits 3 and 4).

Still further evidence of bad faith, actual fraud and conspiratorial misconduct in the handling of the Lavoie claim lies in the testimony and affidavit of Dr. Swan. As a starting premise, the court should carefully note and remember that nowhere in the "Home Office" file produced by Aetna initially at Brenda Harris' deposition and marked as Plaintiffs' Exhibit 3 at TR. 81-100, does there ever appear the two medical reports written by Dr. John B. Douglas, the treating physician. (*Please note carefully the absence of these documents at TR. 81-100*). This conclusion is supported by the testimony of Mr. Hutton who, although having testified in his deposition that the reports of Dr. Douglas were in the Home Office file, admitted at trial that they were, in fact, nowhere to be found in the Home Office file. (R. 484).

With the absence of the medical reports from the Home Office file as a proven, uncontested matter, the question then becomes whether the people who were charged with reviewing the file for approval or denial of a particular claim placed any significance upon the treating physician's reports. This question was answered directly and affirmatively by Dr. Swan:

> "A: . . . What I expect to see is a letter from the doctor, and I would say—I'm volunteering—probably 25% of the time when further information, a letter from the doctor comes, I will change my opinion and recommend coverage for a part of it.
>
> Q: Fine. So you consider then the letter from the doctor to be a very important part of it?
>
> A: I certainly do."

(R. 238-239).

> A: I think the *most important* bit of information we like to get in such cases is a narrative report from the treating physician. It's the *most logical* source of information."

(Dr. Swan at R. 199) (Emphasis added).

Against this backdrop, the court will recall from the evidence set forth hereinabove that not less than two of the four distinct denials of the Lavoies' claim were made by the Hartford claims staff following the submission of the "most important" information contained in Dr. Douglas' reports, and yet no Aetna employee even so much as *contends* that *any* member of the Medical Department *ever* reviewed Dr. Douglas' letters in November or December of 1977, when both of these documented denials were made (compare testimony of Brenda Harris at R. 156-165; testimony of Dr. Swan at R. 193-202; testimony of Mr. Hutton at R 473-485).

Most damning of all, however, is the fact that Dr. Swan, the one and only medical physician at Aetna who could have ever reviewed this "complicated medical matter" "which require(d) a medical opinion", and in direct contradiction to his previous

testimony given in this matter, admitted under oath via affidavit dated February 25, 1980, some one and one half years after the institution of this litigation and over two years after the reports were first submitted by the Lavoies to Aetna, that he had *never once* reviewed either of Dr. Douglas' "most important" letters prior to the date of his affidavit. A careful review of Dr. Swan's affidavit and testimony in this regard is called for.

The affidavit itself was submitted and filed by Aetna in support of a motion for summary judgment (see carefully R. 350 of this transcript where the court file was noted by plaintiffs' counsel as clearly reflecting that an unsigned copy of the affidavit had been previously filed with the court in this litigation). (See also Record on Appeal in *Lavoie vs. Aetna*, Supreme Court case number 80-149, the second appeal of this case where the summary judgment requested by the defendant, Aetna, had been granted).

The signed copy of the affidavit itself was marked as Plaintiffs' Exhibit 8 and is found at TR. 242-243. As pointed out hereinabove, earlier in his testimony, Dr. Swan had testified—though rather gingerly—to the following as regards his second review of the Lavoie file on July 28, 1978:

> "Q: (by Mr. Sintz) Did you also consider Dr. Douglas' letter?
>
> A: Yes. I was thumbing it to try—I was interested in reviewing the letter, whether that is responsive to your question.

(R. 199).

Counsel for plaintiffs would respectfully submit to the court that Dr. Swan's answer *was not* responsive to the question, and reflects the good doctor's attempts to dodge Aetna's own counsel's questioning of him in that respect.

The doctor went on, however, to say that Dr. Douglas' *letter* (he *never* mentions having received but one of the two letters, the 11-4-77 report—see R. 202) did not give him any new

information on which he could change his original opinion. (R200-201).

On cross-examination by plaintiffs' counsel, Dr. Swan was asked about the affidavit which was filed in February, 1980 in support of the defendant's motion for summary judgment. (R. 246). Initially, Dr. Swan denied signing it. (R. 246). Then defense counsel stated that he was not so sure that the original was signed either. (R. 246). Then the good doctor was not sure that he even recalled any such affidavit. (R. 247). He could not see his signature on what was being tendered to him at that time. (R. 247).

Then, after having the doctor sign a blank sheet of paper which was marked as Plaintiffs' Exhibit 34 and found at TR. 297, the original of the affidavit was produced from defense counsel's file and it bore the doctor's signature. (R. 255—see also Plaintiffs' Exhibit 8 at TR. 242). The good doctor then noted that, upon review of his sworn statement, there did not appear to be any reference to his "second review of the doctor's letter or anything." (R. 256). However, it was clear to Dr. Swan upon a closer look that the next to last paragraph of the affidavit stated very clearly that the Medical Department of Aetna had reviewed the file on at least two occasions and that he had reviewed the records twice as of the date he signed the affidavit. (R. 260). This obviously is a reference to his April 28, 1977 review and the July 28, 1978 review. Dr. Swan concludes the affidavit with the statement that, although he had reviewed the file on those two occasions prior to signing the affidavit in February of 1980, he had not yet ever seen any "further information from Dr. Douglas to justify the admission" nor had Dr. Douglas supplied him with such information (see carefully TR. 243, R. 260).

Dr. Swan concluded his testimony on this critical point by denying having sworn to the affidavit (R. 260), but then, after appropriate instructions from defense counsel, suddenly experienced a restoration of his memory and finally confirmed the

truth and correctness of the critical, next to last paragraph of the affidavit. (R. 260-261, TR. 243).

Counsel would respectfully draw the court's attention to R. 262 of Dr. Swan's testimony where, when questioned about his second review of the file in July of 1978, Dr. Swan responded that he was "not too sure" about that date. (R. 262).

Plaintiffs' counsel would again humbly request that the court carefully review Dr. Swan's testimony at R. 246-262 so as to fully grasp the impact and critical nature of the statements made therein.

In plain English, Dr. Swan's sworn affidavit of February, 1980 states unequivocably that, although he had reviewed the file on two occasions (April 28, 1977 and July 28, 1978), and had requested information from Dr. Douglas to substantiate the Lavoie claims, he simply had never seen the two "most important" reports from Dr. Douglas which had been in Aetna's hands for over two years and which he had just sworn falsely to having reviewed at the time of the July, 1978 denial.

PART V

Unbelievably, the evidence did not stop here. In the testimony of Tom Hutton, we find that Mr. Hutton, who had testified in his deposition that he had been the one to take the "most important" medical report to Dr. Swan for review in July, 1978, had never had any contact whatsoever with the file subsequent to his telephone conversations with Brenda Harris in December of 1977. Beginning at page 489, we would humbly ask the court to trace with us the critical nature of Mr. Hutton's testimony in this regard.

Mr. Hutton had testified on direct examination by Mr. Sintz that he had not reviewed the file ever again after December 10, 1977 and prior to the institution of this litigation. (R. 489). He acknowledged that he had not reviewed the file at all when the nurses' notes finally came in in April of 1978. Likewise, he did not review the file at all prior to July of 1978 when the last claims denial had been made by Aetna. (R. 489).

However, Mr. Hutton then was taken through the previous, sworn, under oath testimony that he had given in his deposition where Mr. Sintz had asked him questions regarding whether he had ever remembered seeing both of Dr. Douglas' letters to Aetna. His answer at the time of his deposition was "at a later date, I do" (recall seeing them). (R. 490). A recitation of Mr. Sintz' deposition questions and Mr. Hutton's answers continued:

> "Q: What did you do with them. Can you tell us when it was.
>
> A: Can I look through the files?
>
> Q: Yes if that will help you.
>
> A: Based on this claim file, it would have been around the time of Alice Murphy's referral, the original supervisor in Mobile.
>
> Q: And that is when.
>
> A: That was around July, '78."

Mr. Hutton's examination by Mr. Brown then continued for the jury as follows:

> "Q: So you testified in your deposition that you reviewed the file in July, '78, right sir?
>
> A: Yes.
>
> Q: But you testified today that you have *never* reviewed the file after December 20, 1977 is that right?
>
> A: Yes, that's right.
>
> Q: Did you also testify in your deposition that you also *had occasion to talk with Dr. Swan about the review that you made of the file in July of 1978*?
>
> A: I don't recall.
>
> Q: You don't recall. Talking about Ms. Murphy at page 16 (of his deposition)—'What did she do?' Your answer was

'She referred material up to me for review in addition to nurses' notes which we hadn't had earlier, which we hadn't had earlier for review. . .' Am I reading that right?

A: Yes you are.

Q: Right. (From the deposition)—'And did she resubmit the other portions of the file that she had sent up earlier?' And your answer was, 'I am not completely certain, but that is, but this is how they, the Mobile Claim Office handles claims.' Question: 'Then the file was resubmitted to you for some additional consideration' and your answer was 'Yes.' That would have been what information?

A: You want me to read that?

Q: You read it.

A: (Reading from his deposition)—'That would have been the hospital records which were available the first time around. In addition to the nurses' notes, the subsequent letters from the physician and any attorneys that have been involved. Also any letters from the Mobile Claim Office that would have been pertinent to our review.'

Q: Right sir. And we know, don't we, Mr. Hutton, that the nurses' notes didn't even come in until April of 1978, don't we?

A: Yes.

Q: Alright, and yet your last review had been when, December of '77, according to your testimony today?

A: Yes.

Q: And I asked you, and Mr. Sintz asked you the question (reading from his deposition): Question: (by Mr. Sintz) What did you do with that information. Did you submit to somebody else to look at.' And read for the jury your answer at that time. Read your answer to the jury what you did with that new information.

A: (reading from his deposition) 'Definitely that would have been submitted, because we did have additional medical information that would have been submitted.'

Q: Definitely would have been submitted, and who did you submit it to?

A: That would have been submitted to a member of the, of our Medical Department.

Q: And who do you remember that was?

A: I assume it was Dr. Swan.

Q: And did you have any discussion with Dr. Swan, Mr. Hutton?

A: I don't know. What does that say (indicating toward his deposition)?

Q: Well, let me ask you first. Did you have any discussion with Dr. Swan?

A: No.

Q: No? Do you remember that question being asked you in your deposition? That precise question? Sir?

A: Let' see.

Q: Well, what did you say when that precise question was asked to you by Mr. Sintz? (Reading from deposition question by Mr. Sintz) 'Did you have a discussion with Dr. Swan after he reviewed the file.' What was your answer?

A: (by Mr. Hutton from deposition) 'Yes.'

Q: (Mr. Brown reading from deposition) 'Yes, I did.'

A: O.k.

Q: Is that your answer?

A: Yes, it is.

Q: Do you have trouble with your memory, Mr. Hutton?

A: No.

Q: All of your testimony, then, in your deposition that you gave concerning seeing Dr. Douglas' reports in the spring of 1978 was false, is that true? Sir?"

(R. 491-493) (Emphasis added).

The court sustained defense counsel's objection to the question at this point. However, the answer was indelibly written on Mr. Hutton's face that he had indeed lied under oath in the prosecution of this case. Not only had he lied under oath, and admitted it from the witness stand, but he had lied as to the most critical element involved in this lawsuit, that being, his purportedly having been the individual claims examiner with Aetna who had discussed Dr. Douglas' two "most important" medical reports with Dr. Swan at the time of the second review. (Again note the absence of reference in Mr. Mann's July 25, 1978 handwritten summary to *any* contact with Dr. Swan—TR. 86).

The discovery of Mr. Hutton's admitted perjury provided the missing link in this conspiracy. Immediately, the reason for the absence of Dr. Douglas' two "most important" medical reports from Aetna's Home Office file became apparent:

THEY HAD NEVER BEEN THERE

Immediately, the reasons for Dr. Swan's affidavit to the effect that he had never seen the medical reports from Dr. Douglas was apparent:

THEY HAD NEVER BEEN THERE

Immediately, the reason Mr. Mann's July, 1978 handwriteen and typewritten summaries made no mention of Dr. Douglas' two "most important" medical reports became apparent:

THEY HAD NEVER BEEN THERE

The two "most important" medical reports of Dr. Douglas—the "most logical" source of information—the information upon

which Dr. Swan would change his mind in fully 25% of all cases wherein they were submitted—

HAD NEVER BEEN IN THE HOME OFFICE MEDICAL FILE OF THE AETNA
PART VI

Plaintiffs' counsel would respectfully note for this Honorable Court that the admitted false testimony and literal perjury that had been given by Tom Hutton in his deposition was testimony which was before this court in support of the defendant's motion for summary judgment which was granted by the Trial Court on the second appeal of this case. This admitted false testimony was utilized by the defendant, Aetna, in an attempt to avoid their just desserts under the facts of this case via summary judgment. This admitted false testimony of the senior claims examiner of the defendant who was responsible for two of the four bad faith denials in this case constitutes not only a fraud upon the Lavoies, but is also a fraud committed upon this court.

Such conduct should not be tolerated or condoned by this court's reversal or remititur in any respect of the just judgment rendered by the jury and approved by Judge Zoghby in this case.

ARGUMENT
I
THE EVIDENCE OF BAD FAITH WAS CLEARLY SUFFICIENT TO SUPPORT AN AWARD OF COMPENSATORY AND PUNITIVE DAMAGES IN FAVOR OF THE PLAINTIFFS.

It goes without saying that the tort of bad faith has advanced and developed quite a bit since the Lavoie case first appeared before this court in 1978. Since that time, this court has established the tort of bad faith in the case of *Chavers vs. National Fire & Casualty Co.*, 405 So.2d 1 (Ala. 1981), and has amplified, limited and generally defined the tort on several occasions since *Chavers*.

In *Chavers* this court held that an actionable tort for bad faith arises for an insurer's intentional refual to settle a direct claim where there is either:

> (1) no lawful basis for the denial of the claim coupled with actual knowledge of that fact, or
>
> (2) an intentional failure of the insurer to determine whether or not there was any lawful basis for such refusal.

The *Chavers* opinion further stated that circumstantial evidence as well as direct evidence is sufficient to prove the elements of the tort of bad faith. 405 So.2d at 7.

In the case of *Gulf Atlantic Life Insurance Co. vs. Barnes*, 405 So.2d 916 (Ala. 1981), the Supreme Court further defined the tort of bad faith. The court therein defined "bad faith" as the "intentional failure by an insurer to perform the duty implied by law of good faith and fair dealing." Id. at 924. After reciting the two-tiered test of *Chavers*, Justice Beatty went on to define exactly what those two tests meant:

> "No lawful basis' . . . means that the insurer lacks a legitimate or arguable reason for failing to pay the claim. . . . 'Coupled with actual knowledge of that fact' implies conscience doing of wrong. Bad faith, then, is not simply bad judgment or negligence. It imports a dishonest purpose and means a breach of known duty, i.e., good faith and fair dealing, through some motive of self-interest or ill-will." Id. at 924.

With regard to the second tier of the test for bad faith, Justice Beatty noted that a finding of an intentional failure to determine whether or not there was any lawful basis for refusal could in and of itself be used to prove that no lawful basis for the refusal ever existed.

> "The relevant question before the trier of fact would be whether a claim was properly investigated and whether the results of the investigation were subjected to a cognitive evaluation and review. Implicit in that test is the

conclusion that the legitimate or reasonable basis may be inferred and imputed to an inusrance company when there is a *reckless indifference to facts or to proofs submitted by the insured.*" Id. (Emphasis added).

It is respectfully submitted that the essence of this opinion with regard to the second tier of the test states very clearly that an insurer's reckless indifference to facts submitted to it creates a jury question as to whether or not the insurance company had, *at the time each successive denial was made*, a total lack of a legitimate or reasonable basis for denial. If the insurance company doesn't fairly evaluate a claim based on the information submitted, it is, in fact, the equivalent of no basis at all for the denial.

The case of *National Security Fire & Casualty Co. vs. Bowen*, 417 So.2d 179 (Ala. 1982), was the next in the line of cases defining the tort of bad faith. In this case, the Supreme Court again reiterated the elements of a bad faith action:

"(a) An insurance contract between the parties and a breach thereof by the defendant.

(b) An intentional refusal to pay the insured's claim.

(c) The absence of any reasonably legitimate or arguable reason for that refusal (the absence of a debatable reason).

(d) The insurer's actual knowledge of the absence of any legitimate or arguable reason.

(e) If the intentional failure to determine the existence of a lawful basis is relied upon, the plaintiff must prove the insurer's intentional failure to determine whether there is a ligitimate or arguable reason to refuse to pay the claim." Id. at 1983.

It is important to note that the court, in examining the evidence which was before the insurer at the time the alleged bad faith denial was made in *Bowen*, held that the reasons for denial must be considered in light of the information which was

available to the insurer *at the time the denial was made*. Id. at 183 (emphasis added).

Since *Bowen*, the Supreme Court has twice reiterated this most important factor in determining whether or not an insurer is guilty of bad faith:

> "Whether an insurance company is justified in denying a claim under a policy must be judged by what was before it *at the time the decision is made*." *National Savings Life Insurance Co. vs. Dutton*, 419 So.2d 1357, 1362 (1982); *Federated Guaranty Life Insurance Co. vs. Wilkins*, ____ So.2d ____, 17 ABR 2660 (Ala. 1983). (Emphasis added).

It is respectfully submitted that the reason for the obvious limitation of time and circumstances before the insurer in adjudging whether or not the insurer has been guilty of bad faith is so as to look at the actions of the insurer within the factual framework of the information which it had before it at the time each and every denial of a subject claim was made. In effect, bad faith, if it exists, is determined by those facts which exist and that information which is available at the time each successive denial is made.

Defendant in its brief relies very heavily upon the factual dispute which was placed in evidence by the various physicians which testified at the trial. Plaintiffs respectfully contend that the physician war which occurred at the trial of the case is merely a side show, put on by the defendant to try to obscure, for both the jury and the judge and for this court on appeal, those acts of fraud, conspiracy and intentional deceit perpetrated upon its insured during the course of its handling of the claim. Whether or not reasonable physicians would agree or disagree under the facts of this particular case is absolutely immaterial where the real issues revolve around whether or not Aetna intentionally and knowingly violated its own in-house procedures for properly handling claims—intentionally refusing to review the most important medical information which could be submitted on a given case—intentionally lying to its insureds—intentionally engaging in cover-up activities in an

attempt to whitewash its misconduct—intentionally committing perjury during the course of discovery connected with this case on the most critical issues involved in this case—and intentionally refusing to obtain even so much as the entire hospital chart on Mrs. Lavoie during the course of its four separate and distinct review of this claim prior to the litigation ensuing. As stated, with this type of misconduct it is a given, proven and literally admitted and uncontested matter at the trial of this case, that testimony of the physicians regarding whether or not the length of Mrs. Lavoie's hospitalization and the tests administered to her were reasonable and necessary means absolutely nothing.

Aetna concludes the first section of its argument by stating that the dispute over the reasonableness and necessity of the treatment rendered to Mrs. Lavoie thereby created a factual dispute over whether the contract benefits were due and owing to her and thus the plaintiffs were not entitled to a directed verdict at the close of all the evidence. The defendant goes on to cite the case of *National Savings Life Insurance Co. vs. Dutton, supra,* for the proposition that "if the evidence produced by either side creates a fact issue with regard to the claim the tort claim should not be submitted to the jury." (See defendant's brief at page 20). However, the defendant completely ignored the critical language in the *Dutton* opinion regarding the type of cases wherein the "directed verdict" rule would apply, and made no mention of Justice Jones' amplification in that regard in his special concurring opinion. The critical language, we submit, is:

> "In the *normal* case in order for a plaintiff to make out a prima facia case of bad faith refusal to pay an insurance claim, the proof offered must show that the plaintiff is entitled to a directed verdict on the claim and, thus, entitled to recover on the contract claim as a matter of law. *Ordinarily, if the evidence produced* by either side *creates a fact issue* with regard to the validity of the claim and, thus, the legitimacy of the denial thereof, the tort claim

must fail and should not be submitted to the jury." Id. at 1362. (Emphasis added).

The first thing that the plaintiff would respectfully point out to the court is that none of this language in *Dutton* is meant to retract or modify that language noted in this same opinion to the effect that an insurance compnay's bad faith is adjudged *by what was before it at the time the decision was made.* (See *Dutton* at 1362). Thus, where the *Dutton* opinion later says "if the evidence produced by either side creates a fact issue with regard to the validity of the claim" we simply cannot view that evidence regarding the genuineness of the dispute over the validity of the claim in a void. On the contrary, this evidence must be viewed in the context of the time and circumstances which were before the particular individual or individuals by whom the claim was being reviewed to determine whether or not they had a valid, legitimate basis for denial *at the particular point in time that the denial was made.*

Justice Jones, in his concurring opinion which was overlooked by the defendant, stressed the phrases which we underlined in the quoted passage above. Justice Jones noted with regard to these phrases:

> "These are significant qualifications. Certainly, extreme cases will arise in which a fact issue will present a jury question on that claim."

It is respectfully submitted that the case of *Safeco vs. Sims*, ____ So.2d ____, 17 ABR 2298 (Ala. 1983), a case not cited by the defendant in its brief, further limits and modifies the "directed verdict" requirement of *Dutton*. In that case, the Supreme Court held:

> "We are of the opinion that the finding of a justiciable controversy is not the determining factor of whether there was or was not bad faith on the part of an insurance company to pay a claim. The standard for testing a bad faith claim is not found in either the adjudication of a

> justiciable controversy or the *judgment on the merits of the contact claim.* 17 ABR at 2305.

Again, Justice Jones, in his special concurring opinion, amplified upon the meaning of the quoted language in the majority opinion:

> "The standard for testing a bad faith claim is to be found neither in the adjudication of a justiciable controversy, standing alone, *nor in the judgment on the merits of the contract claim.* This is not to say, of course, that either of these holdings is irrelevant to the bad faith issue. To be sure, the filing of a declaratory judgment action, under appropriate circumstances, may evidence a good faith attempt to seek a prompt resolution of a disputed claim. *If, on the other hand, the refusal to pay is without legal excuse, the mere filing of a declaratory judgment action, followed by a finding of justiciable controversy, may enhance rather than diminish the degree of bad faith.*" Id. at 2307. (Emphasis added).

In commenting directly upon the *Dutton* case, Justice Jones stated:

> "This 'directed verdict on the contract claim' test is not be read as requiring, in every case and under all circumstances, that the tort claim be barred unless the trial court has literally granted plaintiff's motion for a directed verdict on the contract . . . Merely because the insurer may be able to withstand a directed verdict motion—the existence *vel non* of the record entry itself being an issue of fact—would not, as a matter of law, bar the plaintiff's tort claim." Id. at 2308-2309.

Justice Jones concluded with several examples of situations wherein a plaintiff would be entitled to recover under bad faith where he would not be entitled to a directed verdict on the contract claim.

By hypothesis, plaintiffs' counsel would respectfully submit the following situation for the court's review on the issue of

whether bad faith could exist, according to the standards set forth by the defendant in its brief.

By supposition, assume that a hospitalization claim for $20,000.00 was made to defendant insurance company, and that company paid only one-half of the total claim of $20,000.00. Assume further that the company had a contractual obligation to pay the full $20,000.00, and yet, through conspiratorial misconduct among ten of its employees in the medical department and the claims department, created a totally false and absolutely unsubstantiated reason for non-payment of the claim. Assume further that litigation was instituted on this claim for the $10,000.00 benefit which was yet to be paid. Assume that after discovery was taken from all of the ten involved employees from the insurance company, the case proceeded to trial. Assume further that, at the trial, nine of the ten employees of the defendant broke down on the stand, admitting they had lied in their deposition testimony, and agreeing with the plaintiff's contention that they had, indeed, engaged in a conspiracy to deprive the plaintiff of his contractual benefits. Assume, however, that the one remaining employee of the insurance company, perhaps a claim superintendent, insisted consistently throughout his testimony, both in deposition and at trial, that the insurance company had done no wrong.

Under the factual situation set forth hereinabove, and given the scintilla rule in the state of Alabama, there would be a factual dispute over whether or not the contract benefits themselves were owing to the plaintiff. Under these circumstnces, the plaintiff, under the view of *Dutton* expressed by the defendant in its brief, would not be entitled to a dircted verdict on the contract claim (simply because there *was* a factual dispute) and the trial judge *could not* grant a directed verdict in favor of the plaintiff even though the evidence was overwhelming that a gigantic conspiracy had existed. The plaintiff, not being entitled to a directed verdict, would thus not be entitled to go to the jury on the bad faith claim, and would be limited in his recovery to the amount of the contract claim itself.

Such simply cannot be the law. The law of bad faith had as its genesis the very idea of providing a plaintiff who had been victimized by the intentional, wrongful handling of his claim by his insurer the right to recover not only the contract damages he had sustained, but also for the compensatory loss of emotional suffering, humiliation, embarrassement and other compensatory losses, as well as punitive damages for the intentional, malicious, wrongdoing of the insurer. It is elementary that in literally every health insurance claim a defendant insurer will *always* defend its denial of the benefits to its insured based on the grounds that the prescribed treatment was not reasonable or necessary or both, and will put on the witness stand some physician who purports to be reasonable and who will disagree with literally anything that is at issue in the case. *Bad faith* is in the nature of a fraud. It was not created to redress an insured's disappointment over legitimate handling of his claims. It was designed to redress intentional, deceitful, conspiratorial misconduct on the part of an insurer. The law simply cannot impose upon the plaintiff a burden of first being able to eliminate all factual disputes over whether the contract benefits were due and owing to the plaintiff in those situations where actual, intentional, malicious, deceitful misconduct perpetrated upon its insured during the handling of the claim is proven by strong and convincing evidence to the satisfaction of both the jury and the trial judge.

II.
THE PARTIAL PAYMENT MADE BY AETNA CLEARLY IS INSUFFICIENT TO ERADICATE THE EVIDENCE OF BAD FAITH PRESENTED BY THE PLAINTIFFS.

The defendant argues to the court that the partial payment which it made of some of the charges incurred by Mrs. Lavoie during her stay in the Mobile Infirmary of some $1,300.00 of the total $3,000.00 bill serves as a complete defense to the claim of bad faith in this case in accordance with the principles of *Sexton vs. Liberty National Life Insurance Co.*, 405 So.2d 18 (Ala. 1981). The facts in the *Sexton* case indicated that a defendant insurance compnay had paid a substantial portion of the insur-

ed's bills, and this court held that the failure to pay the other part of the claim may very well have been a clerical error under the evidence introduced by the plaiontiff at the time of trial. In the *Sexton* case, however, as opposed to the instant case, there were no real facts which the plaintiff proved which made out a case of actual bad faith, conspiratorial misconduct or fraud on the part of the insurance company in the denial of the portion of the claim that the insurance company refused to pay. As such, the *Sexton* case is easily distinguishable from the Lavoie facts, in that, in this case, plaintiffs exhibited very clearly that literally each and every denial of the Lavoies' claims in the four separate denials of the claim was attended by fraud, recklessness, conspiracy, cheating and an absolute and total disregard for the rights of the insured to have their claim fairly evaluated.

Furthermore, along the lines of *Safeco vs. Sims, supra,* there is clear and convincing evidence in this case that the fraud and cover-up continued on into the legal proceedings themselves and, indeed, even to the point of having the admittedly perjured testimony of Mr. Hutton and others submitted to this Supreme Court on Summary Judgment in this case.

Logic dictates that an insurance company can certainly commit bad faith in the denial of a portion of a claim just as it can in the denial of the entire claim. The defense lawyers will argue that the express language in *Sexton* to the effect that any time any insurance company pays a "substantial portion" of a claim, there is automatically no case for bad faith. This is, we would respectfully submit, illogical and without merit, for what difference does it make if you have a $1,000,000.00 claim and the insurance company pays $200,000.00 or $400,000.00 or $600,000.00 of the claim and then, in admitted bad faith, without any legitimate basis for denial, refuses to pay the other portion of the claim? In the hypothetical situation set forth hereinabove, with admitted bad faith on the part of nine of ten adjustors handling the claim, would the insurance company be insulated from liability simply because it had paid a "substantial portion" of the claim even though they had literally robbed

the insured of the other portion of his rightful benefits? Surely such cannot be the law.

In addition, what is a "substantial portion" of a claim for purposes of the *Sexton* case? Does this mean greater than 50%? Or, in the case of a $1,000,000.00 claim, would $100,000.00 be substantial? If not, would $500,000.00 be substantial? In a $100 claim would $50.00 be a substantial portion? If so, should the insurance company be allowed to escape a judgment for punitive damages and bad faith if it literally robs the insured of the other $50.00? Or $500,000.00?

The defendant argues in conclusion that *Sexton* and *Bowen, supra,* stand for the proposition that partial payment is evidence of a lack of dishonest purpose in refusing to pay the remainder. If indeed this is the law, it cannot be questioned but that the plaintiff not only rebutted this evidence, but also clearly and convincingly obliterated the defendant's "evidence of a lack of a dishonest purpose" in this case by showing that the defendant's handling of their claim on all four occasions of its submission to Aetna was contaminated and infested with the fraudulent and deceitful and conspiratorial misconduct of Aetna.

III.
THE TRIAL COURT DID NOT ERR IN OVERRULING DEFENDANT'S MOTION FOR NEW TRIAL BASED UPON THE ARGUMENT OF EXCESSIVENESS OF THE VERDICT.

The Supreme Court of Alabama recognized early on in the development of the tort of bad faith that public policy considerations dictated that an award of punitive damages would be justified where the defendant's actions in handling the claim of its insured were malicious, wilfull or committed with reckless disregard for the rights of its insured. In the case of *Gulf Atlantic Insurance Co. vs. Barnes, supra,* the court announced that the tortious nature of this action made punitive damages recoverable. The court carefully distinguished between the bad faith conduct which merely gives rise to compen-

satory damages as opposed to that conduct which would justify the imposition of punitive damages. The court noted the case of *Silberg vs. California Life Insurance Co*, 11 Cal.3rd 452, 113 Cal Reptr. 711, 521 P.2d 1103 (1974):

> "It does not follow that because plaintiff is entitled to compensatory damages that he is also entitled to exemplary damages. In order to justify an award of exemplary damages, the defendant must be guilty of oppression, fraud or malice. . . While we have concluded that defendant violated its duty of good faith and fair dealing this alone does not necessarily establish that defendant acted with the requisite intent to injure the plaintiff." 405 So.2d at 925.

The court noted further that Alabama allows recovery of punitive damages when the plaintiff has shown that he suffered at least nominal damage and that the acts complained of were committed with malice, wilfullness or wanton disregard for the rights of others.

> "Thus, for punitive damages to be awarded in Alabama, a defendant must not only intentionally have breached his duty of good faith, but in addition must have committed acts of the nature described above. Recoverable damages may include mental distress and economic loss." Id.

The tort of bad faith has been described as a "species of fraud". *Dumas vs. Southern Guaranty Insurance Co.*, 408 So.2d 86, 89 (Ala. 1981). As such, it is respectfully submitted that the entire body of law concerning fraud and punitive damages which has evolved in this state over the years would be applicable to the tort of bad faith where malice, wilfullness or wanton and reckless disregard for the rights of others has been shown.

The imposition of punitive damages is discretionary with regard to both the enormity of the wrong and the necessity of preventing similar wrongs. *Alabama Power Co. vs. Rembert*, 282 Ala. 5, 208 So.2d 205 (1968); *Treadwell Ford, Inc. vs. Leek*,

272 Ala. 544, 133 So.2d 24 (1961). An effective description of the purpose of punitive damages is found in *Ex parte Smith*, 412 So.2d 1222 (Ala. 1982):

> "It is to punish wrongdoers and to deter others from committing such wrongs that the law sanctions the award of punitive damages. It is a matter of policy of longstanding, the goal of which is the protection of the public from oppressive practices, particularly in the sale of consumer goods." 412 So.2d at 1225.

It is interesting to note that the defendant in its brief without expressly denominating its argument as such, seems to rely heavily on the ratio between the amount of the contract damages and the amount of the award returned by the jury. It has long been established in the state of Alabama that punitive damages need bear no relationship to the actual damages and that they may be greatly in excess of the actual damages. *Johnson Publishing Co. vs. Davis*, 271 Ala. 474, 124 So.2d 441 (1960); *U-Haul Company of Alabama vs. Long*, 382 So.2d 545 (Ala. 1980).

The relationship between insurer and insured is one which was recognized early on in the development of the law of bad faith as requiring special emphasis on the public policy goal of protection of the insured from oppressive practices of the insurer in the handling of first party claims. Indeed, the *Barnes* case noted that:

> "An insured purchases insurance and not an unjustified court battle when he enters into the insurance contract." *Barnes, supra*, 405 So.2d at 925.

However, merely giving lip service to the purpose of punitive damages in such cases (i.e. the punishment and deterence of oppressive, malicious and reckless misconduct) without allowing jury verdicts to stand in their entirety where the insurer has been shown to be guilty of the highest degree of misconduct in its handling of an insured's claim completely undermines the purpose of such damages. Such action merely gives notice to

the insurance industry at large that they need not fear facing a jury for their acts of maliciousness and conspiratorial misconduct, but rather can rest assured in the knowledge that they can always take an appeal and expect that the Supreme Court will remit the judgment by a substantial sum. It is elementary that, until this court decides a "bell cow" case which will set the standard for that degree of misconduct which the Supreme Court will not tolerate, the insurance industry as a whole will continue to appeal every single large verdict in this state with the assurance that they can either settle for substantially less while the case is pending on appeal or can expect the Supreme Court to drastically remit the verdict.

Again, we stress that the very purpose for the imposition of punitive damages is two-fold in its nature: (1) to punish the defendant for his oppressive acts in the particular case at hand *and* (2) to warn or deter others in similar businesses from such conduct in the future. *Badgett vs. McDonald*, 53 Ala. App. 726, 728, 304 So.2d 228 (1974). In such cases, the imposition of punitive damages is discretionary with a jury. *Ford Motor Credit Co. vs. Washington*, 420 So.2d 14 (1982).

This court set forth the guidelines for review of an alleged excessive verdict in the case of *Carlisle vs. Miller*, 275 Ala. 440, 155 So.2d 689 (1963):

> "It is almost platitudinous to restate the guiding rules, but here they are: the verdict of a jury should not be interfered with merely because in the opinion of the court the jury gave too little or too much . . . and the *authority vested in the courts to disturb a verdict of the jury on the ground of excessiveness is one which should be exercised with great caution*. . . Where, as here, there is no set standard for the admeasurement of damages but the damages to be awarded are left to the sound discretion of the jury, a remittitur or a new trial should not be ordered on the ground of excessiveness of the jury verdict except in those cases where the court can clearly see that the verdict has been reached on account of bias, passion,

> prejudice, corruption or other improper motive or cause . . . and only where the damages allowed are so excessive as to warrant the belief that the jury must have been misled by some mistaken view of the merits of the case should the court interfere and set the verdict aside. . . *Also, where the trial court refuses to grant a new trial because he does not believe the verdict is excessive the favorable presumption attending the verdict is thereby strengthened.*" 275 Ala. at 444. (Emphasis added).

It is respectfully submitted that the fact that His Honor, the Honorable Michael E. Zoghby, after closely monitoring the progress of the trial, and keeping much of the plaintiffs' evidence in check during the course of the trial, was nonetheless convinced that the award of the jury to the plaintiffs, given the gravity of the misconduct perpetrated upon the Lavoies by Aetna, was totally justified, and that the verdict should not be disturbed.

The Fifth Circuit has also noted that a reviewing court is not to be concerned with whether the verdict was "just too much" but rather with whether the verdict is the result of passion or prejudice. *Lowe vs. General Motors Corporation*, 624 F.2d 1373, 1383 (5th Cir. 1980). An excellent example of the Fifth Circuit's adherence to that rule can be found in the case of *Dorsey vs. Honda Motor Co. Ltd.*, 655 F.2d 650 (5th Cir. 1981). In that case, the Trial Court had set aside the jury's award of $5,000,000.00 in punitive damages on a Motion for JNOV. The Appellate Court reversed that ruling and reinstated the award and found that:

> "The punitive damage award is thus based directly upon the nature of Honda's conduct." 655 F.2d at 657.

The instant case is one which literally cries out for the imposition of a large punitive damage award. It is respectfully submitted that this court has not yet seen a set of facts wherein the conduct of an insurer has been as reprehensible as the conduct of Aetna was shown conclusively to have been in this case. There is absolutely no hint in the record of the jury being

biased, prejudiced or guided by any improper motive in this case. The trial judge himself was able to observe the demeanor of the witnesses, especially Mr. Hutton, during the examination of them on the witness stand. He likewise was able to observe the demeanor of the jurors during the course of the trial, and with all of this in mind at the time he ruled upon the defendant's motion for new trial, or in the alternative, for remittitur, the trial judge denied their motion, and left the entire verdict of $3.5 million standing. Such a verdict is necessary under the facts of the instant case to not only punish Aetna, but also to give fair warning to others in the insurance industry that such conduct simply will not be tolerated. It is again respectfully submitted that to remit the verdict under the facts and circumstances proven clearly and convincingly by the plaintiffs at the trial of this case will render punitive damages in the context of bad faith cases a toothless watchdog.

It is respectfully submitted that, in the posture in which this case now stands:

> "The only question regarding excessiveness is whether the judicial conscience is quickened by the verdict . . . If the strongest tendencies of the plaintiffs evidence were believed by the jury, such evidence clearly would support a finding of intentional, reprehensible conduct . . ." *Carroll Kenworth Truck Sales, Inc. vs. Leach*, 396 So.2d 1044 (Ala. 1981).

The defendant, in its brief, emptily notes that "the plaintiffs failed to adduce even a scintilla of evidence showing that punitive damages were proper in this case." Likewise, they seem to argue that because none of the defendant's claims examiners spit on the plaintiffs or were rude or nasty to the plaintiffs during the handling of the claims, the plaintiffs have failed in their burden of proving that the defendant acted with malice, fraud and intent to injure. To this we would respond in the words of Justice Jones, as we attempted to in the argument of this case, to the effect that:

> "Indeed a party may be exceedingly nice (even a perfect gentlemen) in his conduct toward the party defrauded and possess all of the malice and oppressiveness contemplated under our willfull deceit statute." *Mobile Dodge, Inc. vs. Patricia Waters*, 404 So.2d 26, 30 (1981).

The plaintiffs would respectfully submit that the judicial conscience of this Supreme Court should not all be quickened in a case wherein not only the strongest tendencies of the evidence, but also the literal admissions of the agents of the defendant, have established in whole or in part that the insurer:

> (a) made its initial denial of the subject claim without any legal justification whatsoever, having no medical opinion to support the denial when it was made;
>
> (b) made a second denial without any medical decision whatsoever being rendered, in violation of the established company procedure for handling such claims;
>
> (c) made a third denial of the claim without any medically qualified opinion to support the denial, again in violation of the company's established procedures;
>
> (d) intentionally misrepresented to the Lavoies that the claim had been repeatedly reviewed by members of the medical department, in an effort to run the Lavoies off, when in fact this was not true;
>
> (e) never had the "most important medical information" available on this file reviewed by any medical doctor with Aetna during the course of the four denials;
>
> (f) through its chief actor involved in the handling of the Lavoie claim, took the witness stand and literally admitted to having committed perjury in the case on the most critical aspects of the handling of the file;
>
> (g) tried to convince the jury that a "25" was a "28" so as to support its otherwise unsupportable denial of the Lavoies' claim;

(h) took the position that a woman who was bleeding bright red blood from the rectum, had flight of ideation, was acutely ill and demonstrated personality changes should have been treated as an outpatient. Without ever having reviewed the portion of the medical record which would have reflected this.

It is respectfully submitted that the strongest tendencies of the evidence presented by the plaintiffs in this case present the strongest facts in any case of bad faith which has yet been before this court. The stipulation of the parties which was before the jury during their deliberation was that the Aetna claims offices employed some 4,500 to 5,000 employees nationwide in 83 regional offices. (R. 566). Surely, this court's conscience should not be quickened by the amount of the verdict which was deliberately set by the jury in response to the Trial Court's proper charge to them to arrive at an amount which will punish the defendant, Aetna, for its wrongdoing, and to give a loud and clear deterent effect to others who would be similarly situated that such conduct would not be tolerated. It is a case of intentional and deliberate wrong, attended by circumstances of fraud, cover-up and conspiratorial misconduct. Certainly, this court's conscience cannot be quickened by the amount of the verdict where the acts of fraud and conspiracy were committed not only upon the Lavoies and their attorneys, but also upon the Supreme Court of the State of Alabama.

IV.
WHETHER THE TRIAL COURT ERRED IN ADMITTING THE TESTIMONY AS TO WHY PLAINTIFFS DID NOT PAY THE HOSPITAL BILL IN QUESTION AND AS TO HOW MUCH THE PLAINTIFFS RECEIVED IN INCOME FOR THE MONTH OF FEBRUARY, 1977.

Before attempting to examine the substance of the Appellant's contentions, certain procedural matters need to be addressed. The issue on appeal centers on testimony given by the plaintiff, Mr. Roger Lavoie at R. 65-66. The objectionable

testimony must be broken down onto its own different sections due to the manner in which each objection was raised.

The first matter to be discussed is whether or not the defendant's objection to the first question of the objectionable testimony on which this issue of the appeal is based is properly reserved for appeal purposes. The question asked of the plaintiff, Mr. Lavoie, was as follows:

> "Q: Well, Mr. Lavoie, why didn't you just go ahead and pay the bill from the Infirmary and wait and see how the outcome of this would be?
>
> A: Because I didn't have the money.
>
> MR. CUNNINGHAM: Your Honor - - "

(R. 65).

It is apparent from the reading of the record that the witness had already answered the question prior to the Trial Court's receiving the objection from the defendant's attorney. This being the case, in order to properly preserve its right to appeal the ruling from the trial court the defense was required to not only object and state a specific ground for the same, but should have moved to exclude the plaintiff's response. There can be no error for the overruling of an objection that comes too late. *Star vs. Star*, 293 Ala. 204, 301 So.2d 78 (1974). If an objection is untimely then in order to preserve the record for appeal purposes a motion to exclude the objectionable portion of the testimony must be made. *Wilkinson vs. Duncan*, 294 Ala. 509, 319 So.2d 253 (1975); *Gilbreath vs. Gilbreath*, 278 Ala. 289, 177 So.2d 915 (1965). The Trial Court will not be put in error for admitting testimony unless an objection was made to the question when asked or unless the answer was not responsive and a motion was made to exclude the same. *Zekoff vs. Franklin*, 380 So.2d 869 (Ala. Civ. App. 1980). In that the defendant did make its objection timely it was under a duty to move to exclude the testimony given by the plaintiff. As a result, the court cannot be placed in error for overruling the objection.

The second area of this question centered around the plaintiffs' total family income for the month of February, 1977. Mr. Lavoie was asked about this and was allowed to give his testimony to the same. The actual reading of the court record is as follows:

> "Q: What was your total family income, you and your wife from Social Security and your disability and your wife's disability in February of 1977?
>
> MR. CUNNINGHAM: Your Honor, that's not relevant at all. As to what his income is has nothing to do with the material involved in this lawsuit.
>
> MR. CROWDER: Your Honor, it's very relevant.
>
> THE COURT: Overrule the objection."

(R. 65-66).

Mr Lavoie went on to testify that his total monthly income was $700.00 during this particular month.

The Appellant alleges in its brief that the only possible purpose of injecting such testimony was to reflect the plaintiffs' poor financial condition to elicit sympathy for the plaintiffs and to arouse passion, prejudice and hostility against the defendant. It is interesting to note that the defendant did not raise this as a grounds for the objection.

The plaintiffs offered proof that the bad faith refusal to pay the amount due for medical care to the Mobile Infirmary resulted in the plaintiffs receiving collection letters and threats of suit from the Mobile Infirmary, a collection agency and an attorney. All of this contributed to and/or caused the plaintiffs to suffer extreme emotional distress.

The law would require the plaintiffs to avoid or mitigate their damages if possible. It is certainly relevant and proper to offer evidence as to why the plaintiffs could not mitigate the damages by simply paying the bill. They couldn't because they

didn't have the money. They only made $700.00 per month to live on and therefore were not able to pay the bill.

The defendant argued that this was not relevant at trial. The test of relevancy is whether or not the evidence offered has any logical relationship between it and the ultimate inference for which it is offered. *McElroy's Alabama Evidence*, § 21.01 (3rd Ed.). Clearly, the evidence offered above meets the test of relevancy. Therefore, the Trial Court properly overruled the defendant's contention that it was not relevant. In any event, the defendant does not contend in its brief that the evidence presented was not relevant, only that it was prejudicial.

An exception to the admission of evidence that is otherwise relevant would be if the prejudicial effect outweighed its probative value. [See Justice Jones' concurring opinion in *Southern Life & Health Insurance Co. vs. Whitman*, 358 So.2d 1025 (Ala. 1978)]. The Evidence given was not prejudicial in that it did not establish the financial condition of the plaintiff. All that was shown by it was that the plaintiff could not pay the subject bill which was necessary to disprove any evidence of their failure to avoid or mitigate damages. In any event, however, the objection stated to the evidence admitted was centered on a relevancy argument. There is no evidence in the transcript, direct or by inference, either at the trial or in the defendant's Motion for New Trial, that the defendant voiced its objection in the premise that it was prejudicial. This matter was not raised until the Appellant stated its grounds in its brief. As such, it cannot raise the issue for the first time on appeal. *Callahan vs. Weiland*, 291 Ala. 183, 279 So.2d 451 (1973). There is nothing to appeal from in that the Trial Court did not have the opportunity to rule on the question of the prejudicial effect, if any, of the testimony offered. The only matter the Trial Court did rule on was the issue of relevancy, which was not raised as an issue on appeal. It is a generally accepted principle in this state that the Trial Court will not be put in error unless the matter complained about was called to the attention of the court by objection or other appropriate method. *Townson vs. Harvey Implement Company, Inc.*, 51 Ala. App. 238 (1973).

It is interesting to note that in its brief, the Appellant makes no reference to the relevancy of the testimony but attacks its prejudicial effect. Upon examination of the transcript, it is evident that the Appellant made no objection concerning prejudice, but rather its objection was centered on the premise that the testimony was not relevant. In that the Appellant has failed to properly preserve the record for appeal, the judgment is due to be affirmed.

The Appellant argues that the testimony given by the plaintiff, Roger Lavoie, was evidence of his poor financial condition. It is interesting to note that the defendant did not object to testimony given by both Mr. and Mrs. Lavoie to the effect that neither one of them was employed during this period of time. (R. 32, 56). Mr. Lavoie testified that he had retired from the Mobile Police Department and was on disability due to brain surgery. (R. 56, 32). Common sense would show that these two individuals were not wealthy people. This testimony would be indicative of their financial condition. As set forth above, it was not objected to. Therefore, the plaintiffs' financial condition was before the jury before any objection to testimony was ever elicited. An error in excluding evidence is harmless where it has been admitted at another time in another form. *Sweatman v. Federal Deposit Insurance Corporation*, 418 So.2d 893 (Ala. 1982).

Based on the foregoing, it appears that the Trial Court did not err in admitting this testimony. The testimony elicited by the plaintiff was relevant. The only question the Trial Court could have considered was whether or not the prejudicial effect of said evidence would outweigh the probative value of the same. This objection was never offered by the defendant and has not been mentioned until the defendant filed its brief. As such, the record for appeal has not been properly preserved and therefore the question cannot come before this Honorable Court. Therefore, the ruling of the Trial Court is due to be affirmed.

CONCLUSION

In conclusion, the plaintiffs would respectfully submit to the Court that the evidence before the jury and judge at the time their respective decisions were made in this case clearly and convincingly show a course of misconduct perpetrated upon the Lavoies by Aetna of the highest degree. Literally every critical witness who testified regarding the internal handling of the Lavoie claim was shown to have been guilty of direct lying to the Lavoies, intentional violation of company policies and procedures, and/or direct lying and/or cover-up regarding the critical matters involved in this case.

Aetna has been caught. Aetna has been given its day in court. The jury, properly impaneled and properly instructed in this case, served not only as the conscience of the community in reviewing Aetna's misconduct, but rather, in the face of evidence of some 4,500 claims adjustors employed by Aetna nationwide in some 83 regional offices, acted as the conscience of the entire nation to clearly and unequivocably announce to Aetna and others similarly situated in the insurance industry that such conduct in the future would not be tolerated and would be severely and thoroughly punished. His Honor, the Honorable Michael E. Zoghby, acted as the thirteenth juror in his role as the trial judge by properly overruling the defendant's motion for new trial and/or remittitur. Aetna now has come to this court, asking for relief from the judgment, while assigning literally no error in the Trial Court's handling of the case, the evidence which was submitted at the trial, the court's charge of the jury, or any other type of misconduct of court or jury during the course of the trial.

In an era wherein we have seen and experienced an avalanche of national advertising by insurance companies, constantly reassuring potential insureds with symbols such as "The Good Hands" and "The Umbrella" to protect one from his or her respective rainy day, and slogans such as "Aetna, I'm glad I metcha", our jurisprudence has already wisely recognized the need and desirability of a remedy in tort allowing for

the recovery of compensatory and punitive damages where an insurer deliberately and intentionally breaches the trust and confidence placed in it by its insured. It is respectfully and humbly submitted that the *Lavoie* case should be embraced by this court as setting forth that type of misconduct which must be shown by clear and convincing evidence in order to sustain an award of substantial punitive damages for bad faith. To overturn or remit the judgment in this case will completely undermine the law of punitive damages, and, instead of delivering a warning to insurers throughout this state regarding the consequences of bad faith, will instead render bad faith the "toothless watchdog" alluded to hereinabove, and will trigger an endless march of appeals through this court with insurers repeatedly comparing their degree of misconduct to that of the defendant, Aetna, in this case and asking the Supreme Court to let them off the hook.

The plaintiffs have prepared, and attach hereto as Exhibit 1, a summary of the four separate denials of the Lavoie claim by Aetna. This Exhibit, together with the transcript of the evidence and this brief should convince this court that the defendant's appeal is without merit, and that the judgment of the Trial Court should be allowed to stand in its entirety.

Respectfully submitted,

CUNNINGHAM, BOUNDS, YANCE,
CROWDER AND BROWN
Attorneys for Appellees

BY:_____
JOSEPH M. BROWN, JR.

BY:_____
JOHN T. CROWDER, JR.

REQUEST FOR ORAL ARGUMENT

In accordance with Rule 34 of the Alabama Rules of Appellate Procedure, and although Oral Argument is not requested by the Appellant, Appellees would respectfully request Oral Argument of the issues and evidence of Bad Faith in this case together with the issue regarding punitive damages and excessiveness of the verdict due to the complex nature of the evidence herein.

CUNNINGHAM, BOUNDS, YANCE,
CROWDER AND BROWN
Attorneys for Appellees

BY:_____
JOSEPH M. BROWN, JR.

IN THE SUPREME COURT OF ALABAMA

Case No. 82-426

AETNA LIFE & CASUALTY INSURANCE COMPANY,
Appellant,

-VS-

MARGARET W. LAVOIE AND ROGER J. LAVOIE,
Appellees.

Appeal From The Circuit Court
Of Mobile County, Alabama

APPELLEES' BRIEF IN RESPONSE TO APPELLANT'S PETITION FOR REHEARING

CUNNINGHAM, BOUNDS, YANCE, CROWDER AND BROWN
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INTRODUCTION

In September of 1978, the plaintiffs, Margaret and Roger Lavoie, filed a complaint in the Circuit Court of Mobile County attempting to state a claim against Aetna Life & Casualty Company for wrongs which had been perpetrated upon them during the handling of an insurance claim by Aetna but for which there had never been any remedies recognized by the Supreme Court of this state. Nearly six and one half years and three appeals later, the majority of this Supreme Court has rendered an opinion which has boldly and honestly brought the law of bad faith out of a series of individual opinions and premises into a full circle of logical and well-defined legal principles which will provide instruction and guidance based squarely upon reason, logic and a genuine recognition of the difference between right and wrong to both bench and bar of this state for years to come. By so doing, this court has drawn the ire of the defendant, Aetna Life & Casualty Company, and its counsel in a manner unlike any that plaintiffs' counsel has ever observed. However, as opposed to having premised its argument upon some sound legal principle or factual basis which this court has overlooked, omitted, or otherwise failed to take into account in its opinion, Aetna has relied solely on bombastic rhetoric, false issues, and unmerited criticism of the majority's opinion in a last-ditch effort to avoid its just desserts in this case.

It is the purpose of this brief not to attempt to answer each and every argument set forth by defense counsel in its brief, for most of the arguments simply do not merit comment. This brief will, nonetheless, attempt to right the wrongs set forth by defense counsel in its brief, state some of the legal principles which have been glaringly omitted from defense counsel's brief, and offer once again in hopefully what will be the final chapter of this saga, a brief review of the evidence from which the jury concluded in this cause a that a judgement in the sum of $3,501,650.22 was both reasonable, necessary, and, indeed, mandated in order to rectify the wrongs perpetrated by the

defendant and its employees during the course of their handling of the medical claim of Margaret and Roger Lavoie.

THE STANDARD FOR REVIEW

Glaringly absent from defense counsel's forty-six pages of argument on this motion for reconsideration is even so much as the slightest glimmer of recognition that the standard for reviewing the correctness of the jury verdict by this Supreme Court demands that the court must review the record in a light most favorable to the appellee. *Cooper v. Peturis*, 384 So.2d 1087, 1088 (Ala. 1980). Defense counsel's refusal to recognize the standard for review as set forth in the above cited case has resulted in a brief on this motion for reconsideration which is nothing more than a rehash of the evidence which was presented to the jury in the trial of this case and, upon which, the jury concluded that Aetna had repeatedly committed acts of bad faith upon its insureds on all four of the reviews and denials conducted by Aetna during the claims handling procedure and which continued through discovery and even into the trial of the case itself. It is respectfully submitted by plaintiffs' counsel that a petition to this court on motion for reconsideration is not the proper forum for the advancing of arguments which have *never* been advanced at *any* previous stage of this litigation and which are literally heard for the first time ever on this motion for reconsideration, nor is it the proper forum for reconsideration of evidence which was properly within the province of the jury for consideration when the verdict was returned. It appears from a review of the defendant's brief that what Aetna would have this court do on reconsideration is to somehow take all of the evidence in the case, throw out the overwhelming weight of the evidence which supported the plaintiff's claim of bad faith against Aetna, and then substitute its own opinion for that of the jury and judge which heard the evidence, returned a verdict, and refused to grant a new trial or a remittitur as requested by the defendant. Certainly, the defendant's requests and pleas in its brief would violate all of the principles of

appellate review recognized in this state, and, as such, should summarily be denied.

The remainder of this brief will attempt to deal with some of the issues raised by defense counsel in very streamlined manner so as to succinctly exhibit to the court the weaknesses contained therein. We would humply submit that our brief in response to the defendant's brief on reconsideration truly pales by comparison with the majority's opinion already rendered in this cause, the opinion itself having answered in advanced and once and for all the charges futilely leveled against it by the defendant.

FORWARD

In Aetna's brief at page two they accuse the Supreme Court of "failure to mention, to meet, to analyze, and to answer certain contentions of the defendant." We would respectfully submit that the defendant's contentions constitute nothing more than fancy legal jargon without substance or merit. The original motion for new trial and appellate brief filed by Aetna in this cause raised only four issues, all of which were squarely and evenly dealt with in the majority's opinion. This motion for reconsideration is not a place for a retrial of the case and for jury arguments or doomsday rhetoric. The jury was entitled under the evidence to render a judgment in this cause, and did so. This Supreme Court has done nothing more than to review the evidence in the light most favorable to the plaintiffs in accordance with long-established appellate principles in this state and to enunciate once and for all in a clear and concise manner that actions such as were perpetrated upon the Lavoies by Aetna will simply not be tolerated in this civilized society.

ISSUE I
WHETHER AETNA LIFE INSURANCE COMPANY FAILED TO INVESTIGATE THE PLAINTIFFS' CLAIM.

In this section of defendant's brief, Aetna attempts to imply that the court has hinged all of the bad faith committed by Aetna in this case on Aetna's "failure to investigate" the claims

submitted variously by the Lavoies. (See pages four and eleven of defense counsel's brief). The plaintiff would respectfully submit that such is a completely facile analysis of the court's opinion and of the plaintiffs' burden of proof and the proof actually submitted at the trial of this case.

This court has cited time and again the case of *Chavers v. National Security Fire and Casualty Company*, 405 So.2d 1 (Ala. 1981) which enunciates the standard of proof in a bad faith action in the following manner:

> (A)n actionable tort arises for an insurer's intentional refusal to settle a direct claim where there is either "(1) no lawful basis for the refusal coupled with actual knowledge of that fact or (2) intentional failure to determine whether or not there was any lawful basis for such refusal."

405 So.2d 7.

The above cited provision indicates very clearly that a plaintiff may recover in bad faith by showing that the insurer knew there was no lawful basis for refusal of payment of the insurance benefits owed or, in the alternative, that the insured intentionally failed to discover whether the refusal to pay was based upon some lawful basis.

The "intentional failure to discover" alternative basis of proving bad faith is discussed and examined further in *Gulf Atlantic Insurance Company v. Barnes*, 405 So.2d 916 (Ala. 1981):

> The second tier of the test is an elaboration on the first. The trier of fact, by finding, on the part of the insurer, an "intentional failure to determine whether or not there was any lawful basis for refusal," may use that fact as an element of proof that no lawful basis for refusal ever existed. *The relevant question before the trier of fact would be whether the results of the investigation were subjected to a cognitive evaluation and review.* Implicit in that test is the conclusion that the knowledge or reckless disregard of the lack of a legitimate or reasonable basis may be inferred or imputed to an insurance company

> when there is a reckless indifference to facts or to proofs submitted by the insured. (Emphasis added).

405 So.2d at 924.

Further, this court has enunciated clearly and succinctly on several occassions that in determining whether or not bad faith exists in a particular case, the conduct of the insurer must be examined within the factual framework "*existing at the time of its actions.*" *National Security Fire & Casualty Company v. Bowen*, 417 So.2d 179 (Ala. 1982). (Emphasis added).

> Whether an insurance company is justified in denying a claim under a policy *must be judged by what was before it at the time the decision is made . . . National Savings Life Insurance Company v. Dutton*, 419 So.2d 1357, 1362 (Ala. 1982); *Federated Guaranty Life Insurance Company v. Wilkins*, 435 So.2d 10 (Ala. 1983).

It is indeed at once interesting and appalling to note that *nowhere* in the defendant's recitation of Issue I in its brief does counsel ever enunciate the principles set forth immediately hereinabove and upon which this Supreme Court has grounded all of its bad faith law since the very inception of the tort in this state. To the contrary, Aetna wishes to extract from the case certain minimal facts - *completely out of their factual context* - focus on an issue which has already been decided adversely to them based upon the overwhelmling weight of the evidence, and, by completely disregarding all appellate principles mandating a review of the evidence in the light most favorable to the appellee, hope that this court will by some miracle invade the province of the jury and reverse the verdict rendered against it.

It is critical to a proper examination of the brief submitted by Aetna on this reconsideration to note that at no time does Aetna ever acknowledge the instructive voice of this Supreme Court in the cases of *Barnes*, *Bowen*, *Dutton*, and *Wilkins*, supra, that the "existence *vel non* of bad faith must be measured not in a vacuum, but under the circumstances, and at the

time the insurer denied the claim." (Slip opinion page twenty-three).

The reason for Aetna's total disregard for the legal principles set forth hereinabove is indelibly etched not in the forty-six pages of their reconsideration brief, but rather in the six hundred pages of trial testimony taken in this cause; for if the evidence is rightfully viewed within the factual framework and proper chronology of events *as they occurred*, it is inescapable that acts of bad faith, fraud, collusion, and conspiratorial misconduct did in fact occur on the part of Aetna in this case.

It in indeed somewhat amazing that Aetna could have the courage under these circumstances to accuse the Supreme Court in its brief of an "anachronistic misconstruction" of certain of the evidence in this cause. (See page fifteen of Aetna's brief). We would indeed respectfully submit unto the court that the only way for Aetna to prevail in this case is to take the evidence in the case out of all chronological context as they have in their brief, and, further, to completely disregard all of the evidence indicating a conspiratorial mishandling of the *Lavoie* file and the later attempted cover-up of the same.

A brief review of the facts within their chronology indicates the following:

a. That Aetna made its initial denial of the subject claim *without any legal justification whatsoever* - the claims office having *no medical opinion* to support the denial as internally required by company procedures when it was made on AprIL 27, 1977 - the first medical review having taken place according to the handwritten notes of Dr. Swan, the handwritten memo of Mr. R. E. Mann, and the testimony of Mr. Hutton on *April 28, 1977*.

BAD FAITH OCCURRED HERE

b. That Aetna made a second denial through an admittedly unqualified claims examiner and without any medical decision whatsoever being rendered, in violation of the established company procedure for handling such claims;

there was absolutely no consultation with a physician on the "most important medical information" in the file.

BAD FAITH OCCURRED HERE

c. Aetna made a third denial of the claim again through its through its admittedly unqualified claims examiner and without any medically qualified opinion to support the denial, again in violation of the company's established procedures.

BAD FAITH OCCURRED HERE

d. Aetna intentionally misrepresented to the Lavoies that their claim had been repeatedly reviewed by members of the medical department in an effort to run the Lavoies off, when in fact this was not true.

BAD FAITH OCCURRED HERE

e. Aetna never had the "most important medical information" which was available on this file from the treating physician reviewed by any medical doctor at Aetna during the course of the four denials.

BAD FAITH OCCURRED HERE

f. Aetna, through its chief claims examiner involved in the handling of the Lavoie claim, Mr. Hutton, took the witness stand and literally admitted to having committed perjury in the case during his deposition and on issues constituting the most critical aspects of the handling of the file.

BAD FAITH OCCURRED HERE

g. In its fourth review and denial of the Lavoie claim, Aetna's senior claims examiner, R. E. Mann, who was conspicuously absent at trial, rendered his opinion on July 25, 1978 that the claim should be denied while *never once* mentioning any consultation whatsoever with Dr. Swan and, further, referencing only the newly submitted nurses' notes as the only additional information in the file

from the previous submission [no reports from Dr. Douglas in file at this time . . . (see carefully Mann's handwritten summary at TR. 86)].

BAD FAITH OCCURRED HERE

It should be carefully noted that in the denials referenced above as points "b" and "c", it is undisputed that *Aetna intentionally refused to pay the claim on both these occasions with absolute and unequivocable knowledge that they had not followed their own in-house procedures dictating the necessity for a review by a medical doctor of "complicated medical problems requiring a medical opinion" and especially with regard to the "most important medical information contained in the claims file."*

Plaintiffs would respectfully submit to the court that, while defense counsel and several other interested insurers in this cause on amicus would have this court reverse or substantially remit the bad faith portion of this award due to the fact that the Lavoies "came out alright in the end", it is inescapable that the Lavoies literally could have been run off at any interval in the above noted recitation of facts which actually occurred in this case, and that, if they had indeed been "run off" by the conspiratorial and fraudulant misconduct of Aetna, a total and complete miscarriage of justic would have occurred. Further, we would respectfully note that had this case been dismissed either on the pleadings, or on summary judgment based in whole or in part upon the admittedly perjured testimony of Mr. Hutton, there would have been a total miscarriage of justice. In this "all's well that ends well" approach to justice, would defense counsel and insurance *amicus* have the criminal cases against thieves nol prossed if they offered to return the stolen money after being captured?

With regard to the charge levied by Aetna at page seven of its brief to the effect that the majority incorrectly concluded that the physical therapy and back brace charges were not paid, plaintiffs' counsel would defy anyone on review of this

case to look at TR. 101, R. 51 and R. 175 referenced by defense counsel at page seven of its brief, and at TR. 101 and TR. 255 referenced at page thirty-nine of defense counsel's brief, and be able to discern whether these charges were or were not paid in this case. (Note carefully that the "brace" charge listed at TR. 101 was incurred on "3/24" and is thus not a part of the hospital charges in issue here). In any event, such argument is immaterial and irrelevant and, at best, grasping at straws, for the contract claim in issue was stipulated to be $1,650.22.

Time and again throughout Aetna's handling of the Lavoie claims, we find documentation in the Aetna file reflective of repeated denials qualified each time by the statement that the individual denial was "based upon the limited information available" or "based upon the information available". These qualifications placed upon the denials are particularly significant, especially in light of the fact that the evidence indicated that the denials were being made by Aetna's claims staff on each successive occasion without having the benefit of the most revealing sources of medical information available to Aetna. The evidence was replete with references to the significance of the nurses' notes, which were not obtained by Aetna until the last of the four denials was made. Likewise, the significance of the doctor's progress records - which indicated in this case that Mrs. Lavoie was suffering from diarrhea and bleeding rectally, and other significant medical and emotional problems - were, as pointed out in the majority opinion, *never obtained* by Aetna. The treating physician's reports, likewise acknowledged by Aetna's own medical doctor as being "the most important" medical information that could be obtained in a review of a file and upon which medical staff would reverse its opinion twenty-five percent of the time, were never reviewed by the medical staff. In light of these facts, there is implicit in the usage by Aetna of the terms "limited information" and "information available" a recognition that if Aetna kept as little information in their files as possible, they could continue to qualifiedly deny the Lavoies' claims indefinitely and could thereby manipulate this claim or any other claim, for that matter, into

"pigeonholed" posture until such time as the Lavoies or some other disgruntled claimant would finally give up and go away.

In conclusion, it is inescapable that, as stated in our introductory comments, Issue I is nothing more than an attempt by defense counsel to reargue and rehash the evidence in this cause, completely disregarding all chronology and appellate guidelines, and to have this court reverse the judgment or allow reconsideration for some improper reason. We would respectfully submit that Issue I contains nothing whatsoever which would merit a reconsideration of the opinion rendered in this cause.

ISSUE II
WHETHER DR. B. R. SWAN, ASSOCIATE MEDICAL DIRECTOR FOR AETNA CASUALTY & SURETY COMPANY RECEIVED AND REVIEWED THE LETTER REPORTS FROM THE LAVOIES' TREATING PHYSICIAN, DR. DOUGLAS.

At the very outset the plaintiffs would respectfully note for this court that nobody - including the entire Aetna claims staff that was involved in this case, Dr. Swan, or, for that matter, the defense lawyers - ever so much as even suggest anywhere in any of the briefs filed in this cause that Dr. Swan ever reviewed Dr. Douglas' second medical report dated December 15, 1977 and found in Aetna's Mobile office file at TR. 116.

It should further be noted that nowhere in the Aetna home office file found at TR. 81-100 are either of the two medical reports submitted by Dr. Douglas.

The court should further note the specific absence in Mr. R. E. Mann's 7/25/78 handwritten review of this file and in his July 28, 1978 inter-office communication of any reference whatsoever to either of Dr. Douglas' two reports generated in November and December of 1977, respectively. See TR. 82 and TR. 86. Please note also that while Mr. Hutton testified in his deposition that the reports of Dr. Douglas were in the home

office file, he admitted at trial that they were, in fact, nowhere to be found in the home office file. R. 484.

Please bear in mind that Mrs. Brenda Harris stated unequivocably that "the medical department has to base their decision on what the doctor informs them (in his doctor's report)" and that this was a hard and fast rule at Aetna with no exceptions. R. 155. In addition, Mr. Hutton testified that he did not consider himself as a senior claims adjustor to be qualified to render a medical opinion. R. 474. "That's why we have our medical department." R. 474. Dr. Swan was consulted on "complicated problems which require a medical opinion." See Swan at R. 187.

Dr. Swan himself testified that he considered "the most important bit of information" that the medical department could receive in cases such as the Lavoie case was a narrative report from the treating physician because it was "the most logical source of information". See Swan at R. 199. Dr. Swan further volunteered at R. 238 and 239 that he would, upon receiving such a report from a treating physician, change his opinion and rcommend coverage in fully twenty-five percent of all cases where such a report was reviewed.

Against this backdrop, an affidavit was produced by plaintiffs' counsel during the examination of Dr. Swan at his deposition. The signed copy of the affidavit itself was marked as plaintiffs' Exhibit 8 and is found at TR. 242-243. The court will recall the rather tentative testimony of Dr. Swan at R. 199 when he asked during the deposition the following as regards his second review of the Lavoie file on ± July 28, 1978 and particularly his review of Dr. Douglas' letter:

> Q: (By Mr. Sintz) Did you also consider Dr. Douglas' letter?
>
> A: Yes. I was thumbing through it to try—I was interested in reviewing the letter, whether that is responsive to your question.

Again, counsel for plaintiffs would respectfully submit to the court that Dr. Swan's answer was not responsive to the question, and reflects his furtive attempt to dodge Aetna's own counsel's questioning of him in that respect. On cross-examination by plaintiffs' counsel, Dr. Swan was asked about the affidavit which was filed in February of 1980 in support of the defendant's motion for summary judgment. R. 246. Initially, Dr. Swan denied signing it. R. 246. Then the lawyer for Aetna stated that he was not sure that the original was signed either. R. 246. Then Dr. Swan was not so sure that he even recalled ever seeing any such affidavit. R. 247. He could not see his signature on what was being tendered to him at that time. R. 247.

Then, after having the doctor sign a blank sheet of paper which was marked as plaintiffs' Exhibit 34 and found at TR. 297, the original of the affidavit was produced from defense counsel's own file and it bore the doctor's signature. R. 255. (See also plaintiffs' Exhibit 8 at TR. 242-243). Dr. Swan then noted that there didn't appear to be any reference to his "second review of the doctor's letter or anything." R. 256. This is amazingly and unbelievably consistent with the argument set forth at the bottom of defense counsel's brief at page fourteen where they contend once again that "the affidavit sets out solely the material that Dr. Swan reviewed during his first review of this file on April 25, 1977." However, even a cursory examination of the next to the last paragraph reveals that the affidavit states very clearly that the medical department of Aetna had reviewed the file on at least *two* occasions and that he, Dr. Swan, had reviewed the records twice as of the date he signed the affidavit. R. 260. This is obviously a reference to his April 28, 1977 review and the July 28, 1978 review, but defense counsel on reconsideration is still convinced that the two reviews unequivocably referenced in the affidavit relate only to the review of "April 25, 1977" (actually April 28, 1977). It is respectfully submitted that perhaps Aetna's total failure to comprehend intrinsic theories of numerical sequencing, Arabic

numerals, and general concepts of chronology could be the very problem that we have been experiencing in this cause.

In any event, Dr. Swan concluded his affidavit with the statement that, although he had reviewed the file on at least two occasions prior to signing the affidavit in February of 1980, he had not yet ever seen any "further information from Dr. Douglas to justify the admission" nor had Dr. Douglas supplied him with such information. (See carefully TR. 243 and R. 260).

To conclude his testimony, Dr. Swan denied having sworn to the affidavit at TR. 260, but then, after appropriate instructions from defense counsel, he suddenly experienced a restoration of his memory and finally confirmed the truth and correctness of this critical, next to the last paragraph of the affidavit. R. 260-261. In plain English, Dr. Swan swore in February of 1980, one and one-half years after his second review of the Lavoie claim, that he had reviewed the file on two occasions (April 28, 1977 and ± July 28, 1978) and had requested information from Dr. Douglas to substantiate the Lavoie claim, but he had simply never seen the two "most important" reports from Dr. Douglas which had been in Aetna's hands for over two years and which he had just sworn falsely in his deposition to having reviewed at the time of the July, 1978 denial.

Please note that all of the foregoing arguments and conclusions and inferences were set out by the plaintiffs in the appellants' brief filed after this case was dismissed by the trial court on summary judgment. This brief was filed with the Supreme Court of the state of Alabama on January 13, 1981 and was responded to by defense counsel. Almost two years later, this case went to trial in November of 1982 and, once again, the precise and identical information, arguments, and conclusions were presented to the jury and judge that tried this case. Both Dr. Swan in July of 1978, were conspicuously absent without explanation at the trial of this cause in November, 1982. Nowhere in any of the three briefs of Aetna filed either on summary judgment or on the appeal of this case do we ever find any

workable explanation or argument in response to the damning evidence elicited from Dr. Swan concerning his affidavit.

Now, for the first time ever, after a brief on summary judgment, an argument on summary judgment before this same court, an opening statement at trial, a three and one-half day trial, a closing statement at trial, two more appellate briefs, and an oral argument before the Supreme Court on this appeal, Aetna's counsel wants to bring up some document in their files in an attempt to explain away the glaring truth of the affidavit of Dr. Swan and his acceptance of that affidavit in his deposition testimony. Clearly, bad faith has occurred once again in the testimony of Dr. Swan and if there were some explanation for that bad faith, Dr. Swan had every opportunity to have explained it away during his deposition tstimony or could have been available to testify at trial after plaintiffs' counsel had clearly and indelibly etched out every inch of the argument to be made on this point in the brief filed on summary judgment in this cause. Clearly, the weak inference raised by defense counsel at this point in the case after all of the arguments and potential explanations that could have been offered is wholly inadequate and totally without merit. This motion for reconsideration is simply not a forum for a rehashing and reconsideration of evidence which was rightfully submitted to the jury and which was totally devastating to the defendant on this critical point. It is respectfully submitted that no further review on this subject is merited, there having been ample evidence from which the jury could conclude that at no time did Dr. Swan actually review Dr. Douglas' reports in any of the four reviews of the claim by Aetna.

ISSUE III

Plaintiffs' counsel does not wish to comment upon whether Aetna was guilty of "legal artifice" in this cause. Instead, plaintiffs would prefer to address this section of the brief to the argument that Dr. Donald Kirby, originally retained by the plaintiffs as an expert in this cause, substantiated in any re-

spect the claims made by Aetna that it was not guilty of bad faith in this cause.

Preliminarily, we would point out that nowhere in the testimony of Dr. Kirby do we ever find any question relating in any manner whatsoever to the fraud and conspiratorial misconduct of Aetna.

The reason for this is obvious. In several instances the defendant has, in its brief, referenced the fact that there was a point in time in this case before which none of the parties were aware of the "critical dates" contained in the Aetna file which revealed that the true issues in this case concerned the fraud, conspiracy, and bad faith perpetrated upon the Lavoies as opposed to any medical issue concerning the propriety of Mrs. Lavoie's treatment. Plaintiffs' counsel would agree with defense counsel in this respect and simply point out to the court that at the time Dr. Kirby was retained, we were of the opinion that the issue in this case would revolve around whether or not reasonable medical physicians could disagree over whether Mrs. Lavoie could have been treated as an outpatient and whether or not the certain (CAT, EKG and EEG) were reasonable and necessary under the circumstances.

An examination of the date of Dr. Kirby's deposition in comparison with the dates of the depositions of Dr. Swan and Mr. Hutton in Hartford, Connecticut tells the story. The record on the second appeal of this case indicates that Dr. Kirby's deposition was taken in Mobile on March 17, 1980. The depositions of Dr. Swan and Mr. Hutton were not taken in Hartford until August 8, 1980. It was not until August of 1980 at the depositions of Dr. Swan and Mr. Hutton that the real fraud issues in this case were discovered. At that point in time, the other issues concerning the propriety of medical treatment under the circumstances became secondary to the real issues of bad faith and conspiracy to defraud permeating Aetna's handling of the Lavoie claims.

Counsel for the plaintiffs would further take issue with Aetna's conclusions that Dr. Kirby agreed with Aetna con-

cerning the propriety of Mrs. Lavoie's treatment. A careful examination of the testimony cited by Aetna and relied upon apparently for the purpose of showing that Dr. Kirby agreed with Aetna in actuality exhibits a very tortured examination of him in an effort to get him to agree with Aetna's conclusions based upon certain hypotheticals. In the end, the only way Aetna's counsel could get Dr. Kirby to agree with him was by hypothecating a situation whereby Dr. Kirby was to assume only the the discharge diagnoses were as given in the discharge summary of Mrs. Lavoie's chart and, based solely upon those discharge diagnoses and nothing else, whether he would question the necessity of a twenty-three day hospitalization under the circumstances. Only then was defense counsel able to elicit a favorable response from Dr. Kirby, and now they argue that these questions, propounded in a void and without reference to the other critical documents in the hospital file, such as rectal bleeding, syncope, flight of ideation, etc., support their position that they were not guilty of any bad faith in this case.

First of all, as pointed out hereinabove, nothing in Dr. Kirby's entire testimony takes into account the actual fraud, bad faith, conspiracy, lying and cheating which was exposed on the part of Aetna during the trial of this case.

Secondly, it is axiomatic that if a questioner continually qualifies and requalifies and restricts and re-restricts his hypotheticals to a witness, thus narrowing the potential answers that could ever be given to the hyperqualified hypotheticals, eventually the witness will change his answer from a "no" to a "yes" based upon such questions. It is respectfully submitted that the weight and credibility to be afforded the answer given under such circumstances is indirectly proportional to the weight, by volume of paper, that it took the questioner to finally elicit the alleged favorable response from the witness.

Be that as it may, the entirety of Dr. Kirby's testimony and defense counsel's direct reliance upon it begs the question in this case because the facts which the jury had before them indicated that all four of Aetna's denials of the Lavoies claims

were bogus as of the time they were rendered and without any legal justification for them at all. As pointed out by the majority in its conclusions, a thousand experts testifying retrospectively on the propriety of Mrs. Lavoie's treatment could not ever change the fact that Aetna recklessly disregarded the facts and proofs of claims submitted by the Lavoies.

Counsel would also take issue with Aetna's tortured reliance upon the recently rendered opinion in the case of *Continental Assurance Co. v. Kountz*. [MS 82-793, Dec. 21, 1984,____ So.2d ____ (Ala. 1984)]. The critical language relied upon by Aetna in that opinion is found in the concurring opinion of Justice Jones to the effect that:

> If the fact finder rejects the factual basis for denial, and that basis is *supplied solely by the testimony of the insurer's agents or employees*, it would be ludicrous to allow such wrongful conduct to defeat, rather than enhance, a bad faith claim.

Aetna would torture the cited language to such an extent as to have this court believe that the simple presence in the case of Dr. Kirby, or of the fact that the City of Mobile Insurance Committee tooks a hands-off approach to this particular claim takes them outside of the "factual basis . . . supplied solely by the testimony of the insurer's agents or employees" language of *Kountz*, and thus gives them a loophole through which to dive and avoid the"*Lavoie* exception."

Such reasoning is, it seems, nothing more than another in a series of facile attempts on the part of Aetna to twist sound legal principles together with tortured facts in an attempt to avoid justice. Their reasoning totally overlooks the fact that Dr. Kirby was never consulted at any time during the four individual denials of the claim. It overlooks the fact that Dr. Kirby was not even consulted until quite some time after this litigation was filed. It overlooks the fact that three of the four fraudulent and conspiratorial denials of the Lavoies claims with their attendant misrepresentations had already been perpetrated upon the Lavoies at the time the City of Mobile Insurance

Committee was ever consulted. It further fails to recite any evidence wherein the City of Mobile Insurance Committee was presented with the true facts of Aetna's intentional mishandling of the Lavoie claim during the presentation of that claim to the committee.

For these reasons, and those previously set forth hereinabove, the plaintifs would respectfully submit that Aetna is not entitled to a rehearing on this appeal.

ISSUE IV
WHETHER THE EVIDENCE OF THE PLAINTIFFS' WEALTH OR POVERTY IS RELEVANT OR MATERIAL TO ANY ISSUE RAISED AT TRIAL.

As pointed out in our original brief in this cause, Aetna in its original brief makes no reference whatsoever to the relevancy of the testimony of Mr. Lavoie on this point, but rather attacked the prejudicial effect of the testimony upon the jury. As pointed out in the majority opinion, such evidence was certainly relevant to the issues attending the damages suffered by the Lavoies. Still further, as pointed out in our brief and even in the brief of the Alabama Defense Lawyers Association offered on *amicus*, it appears that defense counsel failed to properly preserve any error in this respect by timely and appropriate objections, and thus, the trial court cannot be placed in error for having allowed the evidence in at trial. The plaintiffs would respectfully submit that no error has occurred in the Supreme Court's opinion on this issue.

ISSUE V
THE ALLEGED EXCESSIVENESS OF THE VERDICT

This issue is treated amply and fairly in the majority's opinion in this case. The majority's reliance upon the trial judge's ability to observe the demeanor of each witness and the candor with which the witnesses testified at trial is particularly appropriate under the facts and circumstances of this case.

Nowhere in the forty-five pages of brief offered on reconsideration by Aetna do we ever find any reference to or expla-

nation for the perjured testimony offered by Tom Hutton, Aetna's chief actor in this case and an assistant supervisor of claims at the time this case went to trial. The *amicus* brief offered by the Alabama Defense Lawyers Association at page two wishes to water this testimony down, almost winking and smiling to this court as it denotes this critical testimony as nothing more than an "inconsistency" and implying that such testimony is not unusual at all. Plaintiffs' counsel and this Supreme Court certainly recognize that the converse is true and that one would not expect such blatant perjury on such critical facts and especially after the witness had reviewed his own file as often as Mr. Hutton had.

We make no apology for denominating Mr. Hutton's perjured testimony as "perjury", and we further take offense at *amicus* counsel's suggestion that we should be ashamed for having done so. Such argument on the part of *amicus* and Aetna overlooks the fact that the fraud committed by Mr. Hutton's perjured testimony extended not only to the Lavoies and their attorneys but also to the trial court (which granted a summary judgment and which could have been and was intended to be dispositive of this case) and even unto the Supreme Court of the State of Alabama which heard this case on summary judgment. Had it not been for the trial and its exposure of the fact that Mr. Hutton had indeed committed perjury a grave injustice may have otherwise been committed in this cause.

All of the foregoing is to prove that this case is far different from simple negligence or bad judgment on the part of Aetna's personnel as is implied by the brief of Aetna and of *amicus*. It is reflective of a continuing course of misconduct, repeated time after time prior to the institution of this litigation and continuing on through the discovery phases and trial of the case; and even now on reconsideration where defense and *amicus* counsel perform as legal contortionists seeking to twist and pervert sound legal principles to fit the ugly facts of this case.

Aetna likewise suggests in this section of its brief that the Supreme Court should follow some sort of "ratio rule" requir-

ing some relationship between the amount of compensatory damages actually suffered and the punitive damages awarded. Clearly, Alabama has never followed any sort of "ratio rule". In cases such as this, the magnitude of the case itself comes from the enormity of the wrong done rather than from the enormity of the monetary or physical harm suffered. So long as the means and intent to do harm as evidenced by the actions of Aetna are strongly and convincingly supported by the evidence, the enormity of their sin cannot be diminished at all by the contention that only a little monetary damage was suffered.

Likewise, punitive damages awarded in a case such as this cannot be viewed in a vacuum. Recognition must be given to the fact that an insured does not assume an equal bargaining posture with his insurer. Neither does the insured share the fiscal and legal resources immediately available to the isurer. It cannot be forgotten that the insured seeks the protection of his insurer in the hour of his greatest need. Likewise, insurers, including Aetna, have induced the reliance of the general public and their insureds through national advertising campaigns with their familiar emblems and slogans - the "goods hands people" - the "good neighbor policy" - the "umbrella covering all of your insurance needs" - "Aetna, we're glad we metcha".

It is the unique position of trust or fiduciary relationship solicited and assumed by the insurer from its insureds that mandates damages of a differing concept when this trust is breached under circumstances of deceit, fraud, conspiracy and cover-up.

Furthermore, as stated by Justice J ones in *Kountz*, supra:

> The very definition of bad faith failure to pay a valid insurance claim embraces the concept of an intentional injury: *the highest degree of culpability known to the law of torts.* (Emphasis added).

If it is the intentional tort that indeed constitutes the "highest degree of culpability known to the law of torts" what

degree of punishment and deterrence can truly be said to be excessive when that intentional tort is perpetrated by a fiduciary and is attended by fraud, misrepresentation and cover-up of the true facts extending even unto the highest judicial processes of this state.?

Surely, the majority's opinion in this case has adequately covered the topic of excessiveness, and no further discussion is merited here.

ISSUE VI
WHETHER THE DEFENDANT'S FACTUAL BASIS TO DENY A PORTION OF THE PLAINTIFFS' CLAIM WAS SUPPORTED SOLELY BY TESTIMONY OF THE DEFENDANT'S EMPLOYEES AND AGENTS.

Aetna frames this issue at page twenty-eight of its brief and the answer to the question positive must be a resounding "Yes". Again, Aetna has blatantly failed to adhere to the legal rquirements set forth in *Barnes*, *Bowen*, *Dutton*, and *Wilkins*, supra, that the "existence vel non of bad faith must be measured not in a vacuum, but under the circumstances, and at the time the insurer denied the claim." It is inescapable that, in *Lavoie*, the factual basis for denial at the tme each of the four denials was made by Aetna was supplied entirely by employees of the defendant. Aetna's attempt at "bootstrapping" itself into a more handsome position at this point in time must be viewed only as enhancing the bad faith already perpetrated by Aetna upon its insureds.

ISSUE VII
WHETHER THE MAJORITY'S OPINION WHICH REQUIRES THE TRIAL JUDGE TO MAKE DECISIONS CONCERNING THE WEIGHT AND CREDIBILITY OF THE EVIDENCE IN DECIDING WH ETHER TO GRANT OR DENY A DIRECTED VERDICT MOTION IS IN ACCORDANCE WITH ALABAMA LAW.

This question propounded by Aetna at page thirty-one of its brief is somewhat analogous to what plaintiffs' counsel would

respectfully refer to as the "end of the world" argument set forth in many of the briefs filed by *amicus*.

The concurring opinion of Justice Jones in *Kountz*, supra, clearly answers many of the questions raised by Aetna as well *as amicus:*

> *I think it is appropriate, here, to caution the reader that neither Lavoie* nor the instant case should be read as weakening the application of the directed verdict test in a bad faith claim context. It is a valid and useful threshhold gauge, testing whether the bad faith claimant has met the first prong of his *prima facie* burden—that is, whether he was entitled, as a matter of law, to recover on the contract claim. If not, there 'endeth' the tort claim of bad faith. If so, the claimant must meet the second *prima facie* prong: that the insurer acted in bad faith in failing to process or to pay the claim.

Contrary to the suggestions of *amicus* in its briefs, we do not submit nor does *Lavoie* as written require that an insurance company in all cases of medical claims submitted must have a medical doctor to review everything in the file. Nothing in the majority's opinion in *Lavoie* requires this, and a thorough reading of the facts as set forth in the majority's opinion reveals very clearly that the absence of the medical review in this particular case was critical because Aetna had established as a part of its own in-house claims handling procedure that such a medical review was proper and, indeed, mandated only in situations containing complicated medical problems which required a medical opinion for proper review. There is absolutely nothing of a legally horrifying nature in requiring that Aetna adhere to its own policies and procedures in the handling of its "complicated medical problems" and further that it refrain from deliberately and intentionally attempting to defraud its insureds during the course of its claims handling. To the contrary, the majority's opinion states only what any right thinking individual would require under the same circumstances.

ISSUE VIII
WHETHER THE SUBSTANTIAL PARTIAL PAYMENT BY AETNA LIFE INSURANCE COMPANY PRECLUDES A FINDING OF BAD FAITH OR, IN THE ALTERNATIVE, MANDATES A SUBSTANTIAL REMITTITUR.

This issue has been adequately dealt with in the majority's opinion. The stuation in *Lavoie* has been adequately distinguished from the situation set forth in *Sexton v. Liberty National Life Insurance Company,* 405 So.2d 18 (Ala. 1981) and improperly relied upon by the defendant herein. No further treatment of this issue is merited under the circumstances.

ISSUE IX
ALLEGED FACTUAL ERRORS

In this section, the defendant attempts to delineate several areas in the record wherein the majority has wrongfully and/or improperly quoted from the record.

The defendant's lead-off hitter in this section is its contention that certain testimony taken out of the presence of the jury was improperly relied upon by the majority in reaching its conclusion. That testimony is found in specie in the record at R. 99 and constitutes some of the testimony of Brenda Harris, Aetna's Mobile claims adjustor.

It is true that the jury was indeed out of the courtroom during the time that Mrs. Harris testified at this particular point in the record. (See R. 89). However, it is unmistakeable that Judge Zoghby certainly was in the courtroom during the time that this testimony was given and, as such, it could certainly be considered by him and by the Supreme Court in the role that it played in Judge Zoghby's ruling on the post-trial motions filed by the defendant. It will be recalled that this particular testimony of Mrs. Harris concerned her giving of the affidavit some thirty-five days after her deposition testimony which sought to reconcile her testimony concerning the "medical department" at Aetna and her failure to have a medical doctor review the medical reports of Dr. Douglas prior to

her representing to the Lavoies that the claim had in fact been reviewed by a member of the "medical department". Certainly, the defendant cannot contend that Judge Zoghby had no right to observe the demeanor and forthrightness of the witnesses at all points during their sworn testimony - even when the jury was out of the courtroom - and make his final decision regarding new trial or remittitur based upon the entirety of the evidence before him at trial.

However, the critical defect in this argument becomes clear upon an examination of R. 144 in the record. Therein, we find the precise, identical testimony that was elicited out of the presence of the jury at R. 99 given once again in the presence of the *judge and jury.* Accordingly, what the defendant would have this court to believe was improperly relied upon evidence was in any event given before the jury, and the defendant certainly cannot contend that it was harmed in any material respect.

The lead-off h itter has gone down swinging.

Part "B" of this section deals again with arguments which should have been made to the jury. Here the defendant plays fast and loose with the terms "attached material" and "material attached". Again, we have clever manipulation of words and chronology, but none of it is of any substance, and the inferences arising from any such arguments have already been resolved adversely to the defendant.

The rest of the defendant's arguments in this section constitute nothing more than another rehash of the evidence in this case. The critical question is whether or not there was evidence from which the jury could rightfully conclude that the statements made in the majority's opinion were factually correct and supported by the evidence. The answer to this is a resounding "Yes". Beyond this, the defendant merits no consideration whatsoever.

ISSUE X
WHETHER THE ERRORS COMMITTED HAVE RESULTED IN A VIOLATION OF AETNA'S RIGHTS UNDER THE CONSTITUTION OF THE UNITED STATES

First of all, Aetna's arguments concerning a confiscatory and excessive fine and that it has been denied equal protection under the laws of the United States were available to it when this case came up on appeal the first time. These arguments were not among any of the arguments advanced by Aetna in its motion for new trial nor on brief. The rules of appellate procedure do not afford a defendant an opportunity to advance arguments on rehearing for the first time. As such, its petitions in Issue X should be summarily denied.

Secondly, Aetna states in its last paragraph that the Supreme Court's decision in this case is "contrary to any notion of fairness." It is indeed appalling to think that this company, under the facts and circumstances of this case which mandated and required fairness at a very minimum in its dealings with its insured and yet which revealed fraud, conspiracy and repeated intentional wrongs perpetrated upon its insureds, should now petition this court out of "fairness" to "give us a second chance." This plea sounds in equity, and according to equitable principles long recognized in this state, should fall upon deaf ears.

CONCLUSION

It seems somewhat amazing that in a case wherein the overwhelming weight of the evidence clearly indicates a conspiratorial effort to defraud the plaintiffs out of their insurance benefits at a time of their greatest need and peril, the defendant now seeks with venom and anger to strike out at all of those who have exposed the appalling facts of their misdealings with the Lavoies and who have brought them to justice because of these actions. The irony of it all lies in the fact that Aetna, which, according to the great weight of the evidence in this case, lied, cheated and conspired its way through all of its dealings with the Lavoies, and which merits every word of criticism contained in the thirty-nine page majority opinion should now utilized the appellate processes of this state's judicial system to lash out at the Lavoies, their attorneys, the trial court, and, indeed, this Supreme Court in a final desperate attempt to overturn this case.

This Supreme Court has driven the final nail in the coffin of Aetna's misdealings in this cause, and reconsideration should not be the forum for venting their anger at being brought to justice.

Finally, the plaintiffs would respectfully submit to this court that the majority's opinion herein is nothing more or less than a rigorous examination of the facts of this case reviewed in accordance with long established appellate principles in this state. It is a opinion which will bring order to the house of bad faith—an opinion which firmly and indelibly etches in our jurisprudence the line of demarcation between right and wrong—an opinion to which the bench, bar and the general public of this state will point with reverence and pride for generations to come—an opinion containing a clear and definitive statement of what ought to be the law in this state.

If right is still right and wrong is still wrong, then justice has prevailed in *Lavoie*.

Respectfully submitted,

CUNNINGHAM, BOUNDS, YANCE, CROWDER AND BROWN
Attorneys for Appellees

BY: _____
JOSEPH M. BROWN, JR.

BY: _____
JOHN T. CROWDER, JR.

STATEMENT REGARDING AMICUS CURIEA [SIC] BRIEFS

Counsel has attempted in this brief to answer all arguments raised by Aetna in their motion for reconsideration and accompanying brief and has in addition attempted to answer many of the contentions raised by the various *amicus* briefs filed by other interested insurers herein. Unless specifically requested to respond to one or all of the *amicus* briefs filed, appellees would respectfully submit the foregoing brief without further response.

Respectfully submitted,

CUNNINGHAM, BOUNDS, YANCE, CROWDER AND BROWN
Attorneys for Appellees

BY: _____
JOSEPH M. BROWN, JR.

CERTIFICATE OF SERVICE

I hereby certify that I have, on this 16th day of January, 1985, served a copy of the foregoing pleading on counsel for all parties to this proceeding by mailing the same by United States mail, properly addressed and first class postage prepaid.

BY: _____
JOSEPH M. BROWN, JR.

IN THE SUPREME COURT OF ALABAMA

Case No. 82-426

AETNA LIFE & CASUALTY INSURANCE COMPANY,
Appellant,

-VS-

MARGARET W. LAVOIE AND ROGER LAVOIE,
Appellees.

OBJECTION TO MOTION FOR DISQUALIFICATION AND MOTION FOR WITHDRAWAL OF OPINION AND FOR HEARING DE NOVO

Come now the Appellees, Margaret and Roger Lavoie, and object to the motion for disqualification and motion for withdrawal of opinion of December 7, 1984 and for hearing de novo filed by the Appellant, Aetna Life & Casualty Insurance Company, on February 21, 1985 and as grounds for said objection state as follows:

1. The Appellant has failed to meet the burden of proof placed upon it by the laws of the state of Alabama necessary for the disqualification of a single judge or for disqualification of this entire court as requested by the Appellant.

2. The Appellant has failed to show any judicial impropriety in the hearing of the instant cause and the opinion rendered on December 7, 1984 by either Justice T. Eric Embry or by the entire panel of judges sitting en banc in this case.

3. The disqualification of the entire court as moved for by the Appellant, Aetna Life & Casualty Insurance Company, would effectively deny the Appellees their right to have their case heard by the tribunal before which they would be entitled to have the case heard.

4. The failure of the Appellant, Aetna Life & Casualty Insurance Company, to raise the federal constitutional issues of excessive fine, lack of due process, and others, at any time in any of the other pre-trial, post-trial, or appellate proceedings in this matter, operates as an affirmative bar to their being raised for the first time on this motion.

5. The motion for recusal and for hearing de novo filed by the Appellant is untimely.

WHEREFORE, the Appellees respectfully pray that the court will enter an order overruling the motion for disqualification and motion for withdrawal of opinion and for hearing de novo filed by the Appellant in this cause and will further enter an order denying the application for rehearing filed by the Appellant and will enter a final order of judgment affirming the judgment of the Thirteenth Circuit of Alabama awarding $3,501,650.22 to the Appellees herein.

Respectfully Submitted,

CUNNINGHAM, BOUNDS, YANCE,
CROWDER AND BROWN
Attorneys for Appellees

BY: _____
JOSEPH M. BROWN, JR.

CERTIFICATE OF SERVICE

I hereby certify that I have, on this 1st day of March, 1985, served a copy of the foregoing pleading on counsel for all parties to this proceeding by hand delivery of the same.

BY: _____
JOSEPH M. BROWN, JR.

JA-140

IN THE SUPREME COURT OF ALABAMA

Case No. 82-426

AETNA LIFE & CASUALTY INSURANCE COMPANY,
Appellant,

-VS-

MARGARET W. LAVOIE AND ROGER LAVOIE,
Appellees.

BRIEF IN SUPPORT OF OBJECTION TO MOTION FOR DISQUALIFICATION AND MOTION FOR WITHDRAWAL OF OPINION AND FOR REHEARING DE NOVO

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ARGUMENT

I.

WHETHER JUSTICE EMBRY IS DISQUALIFIED FROM SITTING AND DECIDING THE ISSUES RELEVANT TO THIS CASE.

Any discussion of this particular subject matter must begin with the underlying assumption which has been repeatedly stated by the Appellate Courts of this state that "it is presumed that a judge is qualified and unbiased, and one alleging to the contrary has a substantial burden to show the grounds therefore." *Irby v. State*, 429 So.2d 1179 (Ala. Crim. App. 1983). See also *Ford v. Ford*, 412 So.2d 789 (Ala. Civ. App. 1982); *Wells v. Wells*, 346 So.2d 442 (Ala. Civ. App. 1977); *Street v. Hutto*, 46 Ala. App. 324, 241 So.2d 848 (1970).

Specifically, the defendant in this case alleges that Justice Embry has violated the Canons of Judicial Ethics by his participating in the discussions and eventual opinion in this case. The presumptions attending such allegations were specifically addressed in the case of *Reach v. Reach*, 378 So.2d 1115 (Ala. Civ. App. 1979), in the following manner:

> "Canon 3(C)(1) provides in part that a judge should recuse himself in a proceeding in which his impartiality might reasonably be questioned in instances where he has personal bias or prejudice concerning a party. Canon 3(C)(1)(a), *Canons of Judicial Ethics* (1976). Such prejudice is not presumed. *Wells v. Wells*, Ala. Civ. App. 346 So.2d 442, cert. denied, Ala., 346 So.2d 444 (1977); and it is incumbent on the moving party to prove that the bias is of a personal nature. *Pannell v. State*, Ala. Crim. App. 356 So.2d 219, cert. denied, 356 So.2d 222 (1977).
>
> Recusal is not required by mere accusation of bias unsupported by substantial fact. *Wallace v. Wallace*, Ala. Civ. App., 352 So.2d 1376 (1977)."

Id. at page 1117.

Furthermore, and also underlying this entire area of law in the state of Alabama, is that when allegations of this nature are leveled against a member of the judiciary, the allegations standing alone in no way imply the necessity for recusal itself. Simply stated, the party suggesting that such impropriety exists has a heavy burden of proof in showing this, and can simply not hope for recusal based on the mere fact that the allegation is made. See *Acromag-Viking v. Blalock*, 420 So.2d 60 (Ala. 1982); *Taylor v. Taylor*, 387 So.2d 849 (Ala. Civ. App. 1980); *Miller v. Miller*, 385 So.2d 54, cert. denied, *Ex parte Miller*, 385 So.2d 56 (Ala. Civ. App. 1980); *Marr v. Marr*, 383 So.2d 194 (Ala. Civ. App. 1980).

In the case of *Taylor v. Taylor*, 359 So.2d 395 (Ala. Civ. App. 1978), the court recognized the provisions of the Canons of Judicial Ethics calling for recusal of a judge in a situation where he cannot be impartial in hearing a case. Nonetheless, the court went on to further explain that:

> "However, we noted in *Wallace v. Wallace*, Ala. Civ. App., 352 So.2d 1376 (1977), that while Canon 3(C)(1) of the Alabama Canons of Judicial Ethics had the force of law, both judges and the bar should be aware that recusal was not required upon mere accusation of bias unsupported by substantial fact."

Id. at 398.

That is exactly the situation which is present in the case at bar. Defendant has made sweeping allegations of impropriety on the part of a justice of the Supreme Court of Alabama, but has substantiated this with absolutely no evidence whatsoever. Rather, by innuendo and suggestion, they make one last attempt at getting this judgment reversed by suggesting that this entire court is biased, prejudiced against them, and has not given them a fair hearing of all issues presented throughout the extensive course of the appeal of this case. But this court has stated in the past that "bias and prejudice must be shown by the conduct of the trial judge and may not be presumed or inferred by his subjective views." *Hartman v. Board of Trust-*

ees of the University of Alabama, 436 So.2d 837 (Ala. 1983). In fact, it has been definitively stated that:

> "It is settled that a court will be presumed to do its duty when called upon to decide a matter, and it will do so without bias, prejudice or preconceived notions about the case . . . [A] trial judge who is not disqualified or incompetent is duty bound to hear and decide issues and matters brought before him and that his disqualification, should it be raised, must appear from each case."

Ex parte Baggett, 48 Ala. App. 360, 264 So.2d 901 (1972)

The defendant in this case has a clear and unequivocable burden of proving by facts, and not inferences, that Justice Embry should have disqualified himself from participating in the decision and opinion in this case. They have not done so. Instead, they have merely shown that he has pursued and enjoyed the same rights as the rest of the citizens of the state of Alabama by seeking redress through the courts when he believes he has been wronged. This is certainly nothing which would lead one to the conclusion that he should not have fulfilled his sworn duty to participate in the opinion in this case.

II.
WHETHER ALL JUSTICES OF THE SUPREME COURT ARE DISQUALIFIED FROM SITTING AND RENDERING AN OPINION IN THIS CASE.

The defendant in this case has a two-prong attack on why this entire court should recuse itself from sitting and rendering an opinion on this case. The first prong is that because the other eight justices participated in discussions with Justice Embry, whom defendant alleges was not impartial and disinterested, that they themselves were tainted by his discussions and views. The second prong is simply that as potential members of the class of the Blue Cross/Blue Shield filed in the Jefferson County Circuit Court, that all members of this court have become something less than impartial and free from convictions in their approach to the decision in this case.

As to the first prong of this attack, the plaintiffs have previously addressed the question of whether or not Justice Embry should have participated in this opinion, and the natural result of that is that there was no resulting prejudice from any participation by him in conferences or discussions as to this particular case.

As to the second prong, plaintiffs would cite this court to the case of *Carden v. Hand*, 407 F.Supp. 451 (S.D. Ala. 1975). A similar issue was raised in that case, whereby the end result would have been an absolute disqualification of all possible tribunals before which the parties' action could be heard and decided. *Carden* held that in such a situation, if the end result would constitute a denial of a party's right to be heard, and to have justice thus thwarted, a disqualification of the entire court would not be appropriate.

That is exactly the situation which would result as a logical extension of the argument being presented by the defendant in this case. By claiming that the entire Alabama Supreme Court is prejudiced and tainted and unable to render a fair decision in this case, the defendant is in effect attempting to short-circuit the appellate process in its natural function. They suggest the alternative of the appointment of a special court by the governor of Alabama, but the question immediately comes to mind as to whether that would cleanse the harm alleged by the defendant. Since it is the status of all members of the Supreme Court as state employees which offends the defendant, is this same status not going to attach to other judges appointed by Governor Wallace to sit and hear this case? This is all the more reason to reject the second prong of this argument as presented by the defendant, and to leave the prior decision of this court standing as a full and correct review of the matter.

The plaintiffs would further submit to the court that the proposed impaneling of a special court as called for by Aetna would violate the mandate of the voters of the state of Alabama who elected this Supreme Court for the express purpose of hearing and adjudicating not only matters of established case

law but also cases involving questions of first impression. Nowhere in the state of Alabama will we be able to find another body of justices to hear this cause who have been given the approval of the voters of this state to hear cases such as *Lavoie*. Through their votes, Alabama citizens have looked at the various respective judges who sit today on this honorable body and, taking into account their respective pasts, their respective legal careers, their respective interests as lawyers, the respective legal positions which they have championed in their past, and their respective subjective views of the law—both existing and emerging—and have nonetheless given them their vote of confidence and approval to make the law in this state. Any challenge to any individual justice of this court or to the court as a body must certainly establish by clear and convincing proof any alleged impropriety on the part of one or all of the justices hearing this case before it should be allowed to succeed in disempaneling the Supreme Court chosen by the citizens of Alabama.

Of even more importance from a policy consideration standpoint is what the effect of the defendant's arguments carried to their logical extreme would have on the ability of this court to carry out its sworn function on a daily basis. It is not beyond the realm of realistic expectation to suggest that every single decision ever handed down by this court could in some tangential manner touch upon the lives of one or more of its members currently or at some point in the future. Nevertheless, that does not mean that this court is prohibited from carrying out its sworn function of hearing and deciding cases. The end result of the defendant's contention in this regard would strip this honorable court of its ability to sit and hear cases as it is called upon to do, and would in effect create a body which was judicially impotent. By way of illustrative examples, plaintiff offers the following as food for thought on the logical extreme of the defendant's contention in this case:

1. If a judge or close relative of a judge (District, Circuit, Court of Appeals or Supreme Court) has been the victim of a robbery, should that judge recuse himself on all rob-

bery cases that come before his court because his opinion would be tainted?

2. If a judge or close relative of a judge has suffered serious disfigurement, can that judge sit on a case where disfigurement is an issue?

3. If a judge or close relative of a judge has had a bad experience with an automobile dealer on the purchase of a used car that was represented as being new, does that mean that that judge should bring such fact to the attention of all parties prior to trial and can such judge ever sit on another automobile fraud case?

4. If a judge or close relative of a judge has been sued in an automobile accident, does that mean he can never sit as a judge in an automobile accident case?

5. If a judge or close relative of a judge has been the victim of rape, does that mean that that judge can never sit in another rape case?

6. Since judges are paid by the State of Alabama, does that mean they can never sit as impartial arbitors in a case where the State of Alabama is a party?

7. If a judge or close relative has been the victim of medical malpractice, does that mean that that judge can never sit on a medical malpractice case?

8. If a judge or close relative of a judge has been killed in a railroad crossing accident, does that mean that he can never sit on a railroad crossing case? A wrongful death action?

9. Because one of the lawsuits, the subject of this motion, purports to represent all employees of the State of Alabama, does this mean that no judge in the entire State of Alabama could sit and hear a bad faith case as long as the subject case is pending? Could he ever sit on another bad faith case in the future?

10. Should all bad faith decisions since January, 1984 be withdrawn and a new court empaneled to rehear them?

The list could obviously run on ad nauseum and equally absurdum. This is obviously something which is not intended, and can not be tolerated if this court is to serve a useful function. Therefore, it is axiomatic that the defendant's contention that this entire Supreme Court should be removed from consideration of this case should be summarily denied.

III.
WHETHER THIS COURT'S OPINION OF DECEMBER 7, 1984 SHOULD BE WITHDRAWN AND HEARD DE NOVO BY ANOTHER COURT.

Without unnecessarily reiterating everything that has been previously stated by the plaintiffs as to the propriety of this opinion and the manner in which it was heard by this court, this issue should simply be recognized for what it is: a desperate last attempt by the defendant to salvage whatever it can out of the predicament in which it has deliberately and consciously placed itself. The defendant is grasping at straws at this point in an attempt to avoid ever standing up and facing the punishment which has been meted out and repeatedly approved as appropriate. They can cite no Alabama case law whatsoever for the proposition which they suggest, and quite frankly, the plaintiff can see no analogies whatsoever in the authorities cited from neighboring jurisdictions. They simply have no application to the situation which is currently before this court, and therefore have no instructive value.

IV.
WHETHER THE RESULT RENDERED IN THIS CASE WILL DEPRIVE DEFENDANT OF PROPERTY IN VIOLATION OF THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT.

This honorable court is well aware of the long history involved in this case. There were appeals involved before an actual trial on the merits, a full and fair trial was conducted

with the resulting jury verdict supported by overwhelming evidence of misconduct on the part of Aetna, and an exhaustive review through the appellate process has been completed. However, now, for the first time ever, defendant sees fit to raise constitutional due process arguments before this court. The plaintiffs feel compelled to categorize these arguments as exactly what they are. Defendant realizes that it is literally at the end of its jurisprudential rope. They also realize that their only hope of ever getting the verdict overturned is to get out of the state appeals process and hopefully breathe new life into their defense by attempting to leap into the federal court system for a last-ditch salvage operation. In an attempt to do so, they now raise due process arguments for the very first time.

Besides recognizing this as a flagrant affront to the intelligence of this court, it is also an issue which is raised too late and has been waived. As the plaintiffs cited on page 66 of their original brief, issues may not be raised for the first time on appeal, much less after the entire appeals process has been completed and resolved unfavorably against a defendant. See *Callahan v. Weiland*, 291 Ala. 183, 279 So.2d 451 (1973).

In short, the plaintiffs strongly suggest that any constitutional or due process argument should be rejected out of hand as both an attempted sham to further extend the appeals process as well as having been waived by not being raised prior to this point in the appeal. There comes a time when any party's rights to receive the full benefit of all appeals have been exhausted, and the defendant has reached that point.

V.
HAS THE DEFENDANT'S MOTION FOR RECUSAL BEEN TIMELY FILED?

It is a well recognized principle of law that a motion for a judge to recuse him or herself should be filed prior to a determination on the merits. The reason for that is obvious, and was cited in the case of *Roussel v. Tidelands Capital Corporation*, 438 F.Supp. 684 (N.D. Ala. 1977). That is, that without having the element of control inherent in having a motion to recuse

decided before a decision is reached, there is the potential abuse of a party simply withholding information, hoping for a favorable result. If that result is not forthcoming, then the option is always open to raise a belated motion for recusal, thereby hoping to obtain the best of both worlds. Therefore, there is a heavy burden placed on one filing a motion for recusal after a determination has been reached to show good cause for the untimely filing of such.

The cases setting forth the requirements for such a motion have been clear, and very specific. Particularly, they have repeatedly stated that the affidavit in support of a motion for recusal must be signed by a *party* to the litigation, setting forth the facts for the belated filing and the affirmative statement that no knowledge was possessed prior to the date of the filing *by the party* which would have allowed them to file in a timely manner. This has not been done in this case. Instead, an affidavit by the defendant's *attorney* has been filed, in which it is stated that no one *representing* the defendant had any knowledge of this prior to February 14, 1985. The cases interpreting such affidavits have specifically held that an affidavit by an attorney will not suffice and that it must come from a party to the litigation itself. *U.S. v. State of Alabama*, 571 F.Supp. 958; supplemented at 574 F.Supp. 762 (N.D. Ala. 1983).

Upon reviewing the affidavit from defendant's attorney, nowhere in this document is it stated that Aetna Life Insurance Company itself did not have prior knowledge of the facts contained within this affidavit until February 14, 1985. It is merely stated that no one representing them did, and that is a different question. That is one of the underlying bases behind the strict requirements for such affidavits in support of a motion for recusal, particularly when one is filed after a final determination has been made on the issue at hand. Furthermore, how can the attorney for Aetna in this case represent to the court that attorneys representing Aetna elsewhere—in Birmingham or Hartford—had no knowledge of the class action suit filed in Birmingham?

It has even been held that the term "party" as used within that definition does not include the counsel representing one of the litigants in a cause of action. *Davis v. Board of School Commissioners of Mobile County*, 517 F.2d 1044, reh. denied 521 F.2d 814, cert. denied 425 U.S. 944, 96 S. Ct. 1685, 48 L.Ed.2d 188 (5th Cir. 1975).

There is intrinsic in the cases interpreting this type of motion a certain caution or suspicion when such motion is filed after the conclusion of all consideration on the merits of the case. Therefore, the cases have repeatedly held that the movant on such a motion will be held to a strict burden of proof to show good cause for the filing of the motion at that time. Using that standard, the plaintiffs respectfully submit that the defendant's motion is untimely, and that the necessary elements which must be shown to excuse such untimeliness have not been met.

CONCLUSION

In conclusion, the plaintiffs would respectfully submit unto the court that Aetna has fallen miserably short of discharging its heavy burden of proving, by legally sufficient and convincing evidence that there has been any impropriety or violation of the Canons of Judicial Ethics on the part of any member of this honorable court. Further, Aetna has fallen miserably short by failing to timely raise the objections made in its motions. No legally sufficient excuses have been offered by Aetna for the failure to file its motions in a timely manner. Thus the motions as filed should be overruled.

Once again, as we have seen throughout nearly seven years of litigation in this cause, Aetna has failed to honestly present itself to this court by fairly and forthrightly presenting hard, concrete evidence to support its allegations of judicial impropriety. Instead, they have elected to slander this honorable court with bombastic allegations of judicial impropriety without even so much as offering legally sufficient evidence to support their empty allegations. The cases dealing with the

legal sufficiency of affidavits in support of such a challenge are extremely instructive. These cases establish as an absolute requirement the necessity for filing affidavits of parties for the express purpose of disallowing a party to challenge a judgment after the judgment has been entered via recusal motion when the party may very well have known all along that it had a basis for filing its motion for recusal. Under such circumstances, the slander which has been cast upon this Supreme Court by the motions filed by Aetna is utterly intolerable and unforgiveable.

Although it is not a part of this case, the Lavoies would also wish to briefly address a point raised by the motion of *Nationwide* in the companion motions filed by that insurance carrier almost simultaneously with the motions filed by Aetna. Nationwide attempts to make much out of the line of cases between *Barnes* and *Lavoie* which found in favor of the insurance carrier on the issue of bad faith. The plaintiffs would respectfully submit to the court that the development of the tort of bad faith has been nothing more or less than an honest attempt by honest human beings who, despite their own respective backgrounds, legal experiences, former clients, and subjective views of what the laws should be, have forged out a definition of exactly what this new tort should consist of. We must respectfully submit that when objectively viewed in the light of the wrongs which the tort of bad faith seeks to right and the factual context out of which the tort has arisen, this tort has been given a fair, well-founded and well-defined basis by this court which will provide guidance to plaintiffs, insurance carriers, bench and bar for years to come.

Finally, it is at once distressing and practically unbelievable that an insurance carrier, who was shown by clear and convincing evidence to have been guilty of literal lying, cheating, deception, and admitted perjury throughout the handling of the Lavoies claim, the pre-trial aspects of this case, and up to and including the trial itself, can now come to this Supreme Court with an empty motion for recusal and disqualification of an honorable justice of this court and indeed this entire honorable court. Aetna stands before this court dirtied by the revela-

tions of the evidence which proved that they acted through their employees with a malignant heart in all of their dealings with their insureds and continued the perpetration of their fraud even unto the trial court and to the Supreme Court of the state of Alabama. They stand now before the court and point a bloody finger not just at the Honorable Justice Embry, but at the entirety of the court with the allegation that "someone must have cheated us." But beyond this bare allegation, Aetna has brought nothing with it to the court in proof of its allegations. It is at the end of its jurisprudential rope. There is no substance in its allegations, and its briefcases are empty. It is time that Aetna met its just desserts.This case involves a 5-4 decision. This decision, it is respectfully submitted, has been made by honest human beings doing their level best to achieve justice according to their own views of what the laws should be as applied to the horrible facts of this case.

The motion for recusal and for disqualification of a justice of this court and of the entirety of the court itself is altogether a different matter. It is slanderous and is a blight on the legal community of this state and should not be tolerated. Whether the decision in *Lavoie* stands the test of reconsideration or not, we would respectfully submit that this court should unite as one in issuing to Aetna a firm and unanimous answer that there has been no judicial impropriety whatsoever in meting out the judgment which has rightfully exposed and punished Aetna for its wrongdoings in this cause.

Respectfully submitted,

CUNNINGHAM, BOUNDS, YANCE,
CROWDER AND BROWN
Attorneys for Appellees

BY: _____
JOSEPH M. BROWN, JR.

CERTIFICATE OF SERVICE

I hereby certify that I have, on this 1st day of March, 1985, served a copy of the foregoing brief on counsel for all parties to this proceeding by hand delivery of the same.

BY: _____

JOSEPH M. BROWN, JR.